

**AETNA HEALTH INC.  
(TEXAS)**

**GROUP AGREEMENT COVER SHEET**

**Contract Holder:** City Of Mineral Wells

**Contract Holder Number:** 208434  
001

**HMO Referred Benefit Level:** CITIZEN PLAN Benefits Package

**Effective Date:** 12:01 a.m. on October 1, 2011

**Term of Group Agreement:** The **Initial Term** shall be: From October 1, 2011 through September 30, 2012  
Thereafter, **Subsequent Terms** shall be: From October 1st through September 30th

**Premium Due Dates:** The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.

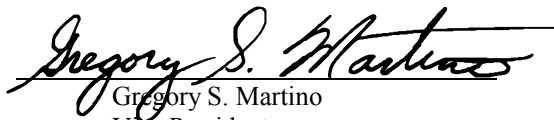
**Governing Law:** Federal law and the laws of Texas.

**Notice Address for HMO:**  
HMO Contracts, F756  
P.O. Box 91503  
Arlington, TX 76015

The signature below is evidence of Aetna Health Inc.'s acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health Inc.

**AETNA HEALTH INC.**

By:

  
Gregory S. Martino  
Vice President

**Contract Holder Name:** City Of Mineral Wells

**Contract Holder Number:** 208434

**Contract Holder Locations:** 001

**Contract Holder Group Agreement Effective Date:** October 1, 2011

**AETNA HEALTH INC.  
(TEXAS)**

**GROUP AGREEMENT**

This **Group Agreement** is entered into by and between AETNA HEALTH INC. (“HMO”) and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

**This is not a policy of workers’ compensation insurance. The employer does not become a subscriber to the workers’ compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers’ compensation laws. The employer must comply with the workers’ compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.**

Upon acceptance by **Us** of **Contract Holder’s** Group Application, and upon receipt of the required initial **Premium**, this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

**SECTION 1. DEFINITIONS**

- 1.1 The terms “**Contract Holder**”, “**Effective Date**”, “**Initial Term**”, “**Premium Due Date**” and “**Subsequent Terms**” will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:
- “**Effective Date**” would mean the date health coverage commences for the **Contract Holder**.
  - “**Initial Term**” would be the period following the **Effective Date** as indicated on the Cover Sheet.
  - “**Premium Due Date(s)**” would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
  - “**Subsequent Term(s)**” would mean the periods following the **Initial Term** as indicated on the Cover Sheet.
- 1.2 The terms “**HMO**”, “**Us**”, “**We**” or “**Our**” mean Aetna Health Inc.
- 1.3 “**Certificate**” means the Certificate of Coverage issued pursuant to this **Group Agreement**.
- 1.4 “**Grace Period**” is defined in Section 3.3.
- 1.5 “**Group Agreement**” means the **Contract Holder’s** Group Application, this document, the attached Cover Sheet; the **Certificate** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.
- 1.6 “**Interested Parties**” means the **Contract Holder**, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an **Interested Party**.
- 1.7 “**Party, Parties**” means **HMO** and **Contract Holder**.

- 1.8 **“Premium(s)”** is defined in Section 3.1.
- 1.9 **“Renewal Date”** means the first day following the end of the **Initial Term** or any **Subsequent Term**.
- 1.10 **“Term”** means the **Initial Term** or any **Subsequent Term**.
- 1.11 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **Certificate**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **Certificate**, the terms of this **Group Agreement** shall prevail.

## SECTION 2. COVERAGE

- 2.1 **Covered Benefits.** We will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.
- 2.2 **Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **Certificate** in order to promote orderly and efficient administration.

### SECTION 3. PREMIUMS AND FEES

- 3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the “**Premium**”) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.5 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.4 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.
- 3.2 **Fees.** In addition to the **Premium**, **We** may charge the following fees, as permitted by law:
- An installation fee may be charged upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of **Members** or a change in the method of reporting **Member** eligibility to **Us**). A fee may also be charged upon initial installation for any custom plan set-ups.
  - A billing fee may be added to each monthly **Premium** bill. The billing fee may include a fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.
  - A reinstatement fee as set forth in Section 6.4.
- 3.3 **Past Due Premiums and Fees.** If a **Premium** payment or any fees are not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** and fees are not received before the end of a 31 day grace period (the “**Grace Period**”), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.
- If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** and fees due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period**. **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period**. In the event of non-payment of any amount due, **We** shall be entitled to all remedies provided for in law or in equity.
- 3.4 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

- 3.5 **Changes in Premium.** We may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of any **Premium Due Date** upon 30 days prior written notice to **Contract Holder**, provided that no such adjustment will be made during the **Initial Term** except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**.
- 3.6 **Membership Adjustments.** We may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **Certificate**, and are subject to the payment of all applicable **Premiums**.

#### SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **Certificate**, **Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **Certificate**, other enrollment periods may apply.

4.2 **Waiting Period.** There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **Certificate** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

## SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement**, **Contract Holder** agrees to:

- 5.1 **Records.** Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**. **We** will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:
- until stopped by the **Contract Holder**;
  - if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
  - if **Subscriber** stopped working due to disability, not beyond the end of the 30<sup>th</sup> policy month after the month in which the absence started.
- 5.2 **Access.** Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.
- 5.3 **Forms.** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.
- 5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.
- 5.5 **Continuation Rights and Conversion.** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.
- 5.6 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.



## SECTION 6. TERMINATION

- 6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days' prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or its agent of intent to terminate.
- 6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified, the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder**, **We** may accept an oral indication by **Contract Holder** or its agent of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.
- 6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Upon 15 days' notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
  - Upon 30 days' notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;
  - Upon 30 days' written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (iv) changes its eligibility or participation requirements without **Our** consent;
  - Upon the first **Renewal Date** following 6 consecutive months of failure by **Contract Holder** to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request);
  - Upon 90 days' written notice to **Contract Holder** if **We** cease to offer the product to which the **Group Agreement** relates;
  - Upon 180 days' written notice to **Contract Holder** if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;
  - Upon 60 days' written notice to **Contract Holder** for any other reason which is acceptable to the Department of Insurance and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended; or
  - Upon 30 days' notice to **Contract Holder** if an association group, the **Contract Holder's** membership in the association ceases.
- 6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of

Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

- 6.5 **Notice to Subscribers and Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

## **SECTION 7. PRIVACY OF INFORMATION**

- 7.1 **Compliance with Privacy Laws.** We and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.
- 7.2 **Disclosure of Protected Health Information.** We will not provide protected health information (“PHI”), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from Us, unless **Contract Holder** has either:
- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder’s** plan documents to incorporate the necessary changes required by such rule; or
  - provided confirmation that the PHI will not be disclosed to the “plan sponsor”, as such term is defined in 45 C.F.R. § 164.501.
- 7.3 **Agents and Consultants.** To the extent any agent or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such agent or consultant is acting on behalf of **Contract Holder** and not Us. We are entitled to rely on **Contract Holder’s** representations that any such agent or consultant is authorized to act on **Contract Holder’s** behalf and entitled to have access to the PHI under the relevant circumstances.

## SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

- 8.1 **Relationship Between Us and Participating Providers.** The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

**Participating Providers** are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

- 8.2 **Relationship Between the Parties.** The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

## SECTION 9. MISCELLANEOUS

- 9.1 **Delegation and Subcontracting.** **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.
- 9.2 **Accreditation and Qualification Status.** **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.
- 9.3 **Prior Agreements; Severability.** As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.
- 9.4 **Amendments.** This **Group Agreement** may be amended as follows:
- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
  - By written agreement between both **Parties**; or
  - By **Us** upon 30 days written notice to **Contract Holder**.
- The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.
- 9.5 **Clerical Errors.** Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of **Premiums** shall be made. **We** may also modify or replace a **Group Agreement**, **Certificate** or other document issued in error.
- 9.6 **Claim Determinations.** **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **Certificate** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.
- 9.7 **Misstatements.** If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.
- 9.8 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by a **Subscriber** on an enrollment application shall be the basis for voiding, canceling or non-renewing a **Member's** coverage unless a signed copy of the enrollment application is or has been furnished to the **Subscriber** or the **Subscriber's** personal representative.
  - No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- 9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.
- 9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.
- 9.11 **Notices.** Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.
- 9.12 **Third Parties.** This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.
- 9.13 **Non-Discrimination.** **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.
- 9.14 **Applicable Law.** This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.
- 9.15 **Inability to Arrange Services.** If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
- 9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.
- 9.17 **Dispute Resolution.** **HMO** and **Interested Parties** (the "Parties") may agree to binding arbitration to resolve any controversy, dispute or claim between them arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). Said binding arbitration shall be administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator

("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the Parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. Should the Parties agree to resolve their controversy, dispute or claim through binding arbitration, said arbitration shall be held in lieu of any and all other legal remedies and rights that the Parties may have regarding their controversy, dispute or claim.

If the Parties do not agree to binding arbitration, nothing herein limits any right the **Interested Parties** may have to file: an action seeking monetary or equitable remedies under other state or federal statutes or regulations; a complaint with the Texas Department of Insurance; or a class action pursuant to and in accordance with the Texas Insurance Code Article 21.21 (relating to unfair competition and unfair practices.)

- 9.18 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

- 9.19 No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

## **HEALTH CARE REFORM CONTRIBUTION CHANGE NOTICE**

If you maintain a grandfathered health plan as defined under The Patient Protection and Affordable Care Act and you intend to make a change in the contribution rate at any point during the year, you must provide written notice to Aetna 60 days in advance of the effective date of the contribution rate change.



**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE GROUP AGREEMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

**Aetna Health Inc.**, (“**Aetna**”) and **Contract Holder** agree to provide to the following provisions:

“Prorations”, Section 3.4 of the Group Agreement is deleted and replaced by the following:

- 3.4     **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

**Premiums** for **Members** whose coverage terminates on a day other than the last day of the billing month shall be adjusted as indicated below:

The **Contract Holder** is liable for **Member’s Premiums** from the time the individual is no longer part of the eligible group until the end of the month in which the **Contract Holder** notifies **Aetna** that an individual is no longer part of the eligible group.

For the purposes of this section, “month” means the period from a date in a calendar month to the corresponding date in the succeeding calendar month. If the succeeding calendar month does not have a corresponding date, the period ends on the last day of the succeeding calendar month.

Examples:

- For calendar months with succeeding corresponding dates: May 5<sup>th</sup> to June 5<sup>th</sup> would equal one “month”.
- For calendar months without succeeding corresponding dates: January 31<sup>st</sup> to February 28<sup>th</sup> would equal one “month”.

If a **Contract Holder** provides at least 30 days’ prior notice to **Aetna** of an individual’s ineligibility for coverage, liability for **Premium** payments and for coverage by **Aetna** ceases on the date the individual leaves the group.

If the individual obtains subsequent coverage before the end of the month in which the **Contract Holder** has given **Aetna** notice, including any state or Federal continuation coverage, liability for **Premium** payments and for coverage ceases on the date the individual leaves the group. **Aetna** may ask the **Contract Holder** to verify the subsequent coverage and to agree to be responsible for payment of **Premium** if the individual’s new health plan does not cover the individual through the end of the month in which **Aetna** was notified about the loss of eligibility.

**Aetna** may ask the **Contract Holder** to verify the subsequent coverage and to agree to be responsible for payment of **Premium** if the individual’s new health plan does not cover the individual through the end of the month in which **Aetna** was notified about the loss of eligibility.

In some instances, a three-day grace period may apply. It applies when:

- The individual has ceased to be eligible within seven calendar days prior to the end of the month; and
- **Aetna** has received notice from the **Contract Holder**, via a method agreed upon by the **Contract Holder** and **Aetna** which provides immediate notification to **Aetna**, no later than the end of the grace period.
- If notification is given within the seven calendar days prior to the end of the month, then notification may be made by any method, including U.S. Mail.

This provision will not apply in instances where an eligible dependent student is terminated without **Contract Holder** notice. In cases where **Aetna** relies on **Contract Holder** notice to effect the termination, this provision will apply.

This provision does not apply if the entire group is terminated for any cause.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE  
TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY  
ASSOCIATION**

**(For insurers declared insolvent or impaired on or after September 1, 2005)**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

**It is possible that the Association may not cover your policy in full or in part due to statutory limitations.**

**Eligibility for Protection by the Association**

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time (**irrespective of the policyholder's residency at policy issue**)
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

**Limits of Protection by the Association**

**Accident, Accident and Health, or Health Insurance:**

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

**Life Insurance:**

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on any one life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

**Individual Annuities:**

- Present value of benefits up to a total of \$100,000 under one or more contracts on any one life.

**Group Annuities:**

- Present value of allocated benefits up to a total of \$100,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

**Aggregate Limit:**

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

**Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.**

Texas Life, Accident, Health and Hospital  
Service Insurance Guaranty Association  
6504 Bridge Point Parkway, Suite 450  
Austin, Texas 78730  
800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

Texas Department of Insurance  
P.O. Box 149104  
Austin, Texas 78714-9104  
800-252-3439 or [www.tdi.state.tx.us](http://www.tdi.state.tx.us)

AETNA HEALTH INC.  
TEXAS  
3 Greenway Plaza, Suite 400  
Houston, Texas 77046  
713-350-2150 or 1-800-323-9930

**CERTIFICATE OF COVERAGE**

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna Health Inc., hereinafter referred to as **HMO**, and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. The **Certificate** describes covered health care benefits. Provisions of this **Certificate** include the Schedule of Benefits, any riders, and any amendments, endorsements, inserts or attachments. Riders, amendments, endorsements, inserts or attachments may be delivered with the **Certificate** or added thereafter.

**HMO** agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

Coverage is not provided for any services received before coverage starts or after coverage ends except as shown in the Continuation and Conversion section of this **Certificate**.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

**The Group Agreement under which this Certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas.**

**READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**

**IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY HMO.**

**NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS, SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT. IF THE GROUP AGREEMENT IS TERMINATED FOR NON-PAYMENT OF PREMIUM, THE MEMBER WILL BE RESPONSIBLE FOR THE COST OF SERVICES RECEIVED DURING THE GRACE PERIOD.**

**THIS CERTIFICATE OF COVERAGE CONTAINS A BINDING ARBITRATION PROVISION.**

**THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.**

**PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO.**

**Important**

**Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming**

the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

**Contract Holder:** City Of Mineral Wells

**Contract Holder Number:** 208434

**Contract Holder Group Agreement Effective Date:** October 1, 2011

## IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at:

**1-800 MY Health (694-3258)**

You may also write to Aetna at:

**Aetna Health Inc.**

2777 Stemmons Freeway, Dallas, TX 75207

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance at:

P.O. Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### **ATTACH THIS NOTICE TO YOUR POLICY:**

This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Aetna Health Inc. para informacion o para someter una queja al:

**1-800-MY-Health (694-3258)**

Usted tambien puede escribir a Aetna:

**Aetna Health Inc.**

2777 Stemmons Freeway, Dallas, TX 75207

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### **DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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## **HMO PROCEDURE**

### **A. Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

A **Member** who has been diagnosed with a chronic, disabling or life threatening illness may apply to the **HMO's** medical director to be able to select a **Participating Specialist** as the **Member's PCP**. The **HMO** will specify to the **Member** the information necessary, including certification of the medical need, and signatures of the **Member** and the **Participating Specialist** interested in serving as the **Member's PCP**. The **Participating Specialist** must meet the **HMO's** requirements for **PCP** participation and be willing to accept the responsibility to coordinate all of the **Member's** healthcare needs. The designation of the **Participating Specialist** as the **Member's PCP** will not be retroactive. If the request for special consideration of a **Participating Specialist** is denied, a **Member** may appeal the decision through the **HMO's** established **Complaint** procedure.

### **B. The Primary Care Physician.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to another **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

Certain **PCP** offices are affiliated with **Limited Provider Networks** or **Delegated Networks**, and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

In certain situations where a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. Please refer to the Covered Benefits section of this **Certificate** for details.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

### **C. Availability of Providers.**

**HMO** cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.



D. **Availability of Coverage in the Event of a Provider Termination**

1. Except as stated below, if the agreement between **HMO** and the **Member's** current **PCP** terminates, the **Member** must select a new **PCP**. If the **Member** does not select a new **PCP**, benefits will be limited to coverage for **Medical Emergency** care.
2. Except as stated below, if the agreement between **HMO** and a **Provider** to which the **Member** has a standing **Referral** terminates, the **Member** will be referred to a different **Participating Provider**.
3. If requested by the **Member's** terminating **PCP** or **Provider**, a **Member** may continue receiving **Covered Services** from such terminated **PCP** or **Provider** under the following conditions:
  - Up to 90 days, if the **Member** has a disability, acute condition or life threatening illness;
  - Up to 9 months, if the **Member** has been diagnosed with a terminal illness;
  - Through delivery of the child, immediate postpartum care and follow-up check-up within the first 6 weeks after delivery, if the **Member** is past the 24<sup>th</sup> week of pregnancy;

These choices will not be available if **HMO's** termination of the **Provider** is based on:

- imminent harm to **Member's** health,
- action against the **Provider's** professional license,
- **Provider** fraud, or
- failure of the **Provider** to satisfy credentialing criteria.

E. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the Member Services toll-free telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request.

F. **Ongoing Reviews.**

**HMO** conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** and the **Health Professional** will be notified of the specific reasons and rationale for determining that the proposed course of treatment, health care service or supply is not a **Covered Benefit**. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination. Please refer to the Complaint Procedure section of this **Certificate** for an explanation of the **Complaint** process.

G. **Provider Communication.**

**HMO** will not prohibit, attempt to prohibit or discourage any **Health Professional** from discussing or communicating to a **Member** or a **Member's** designee any information or opinions regarding the **Member's** health care, any provisions of health care plan as it relates to the medical needs of the **Member** or the fact that the **Health Professional's** contract with the **HMO** has terminated or will no longer be providing services under the **HMO**.

H. **Out-of-Network Services.**

If the **Member's PCP** is part of a practice group or association of **Health Professionals** and **Medically Necessary Covered Services** are not available within the **PCP's** limited provider network, the **Member** has the right to a **Referral** to a **Participating Provider** outside the **PCP's** limited provider network. If **Medically Necessary Covered Benefits** are not available from **Participating Providers**, **HMO** will allow a **Referral** to a non-participating **Provider**. The following apply:

1. The request must be from a **Participating Provider**.
2. Reasonably requested documentation must be received by **HMO**.
3. Before **HMO** denies a **Referral**, a review will be conducted by a **Specialist** of the same or similar specialty as the type of **Provider** to whom a **Referral** is requested.
4. The **Referral** will be provided within an appropriate time, not to exceed five business days, based on the circumstances and the **Member's** condition.
5. The **Member** shall not be required to change his or her **PCP** or **Participating Specialist** to receive **Medically Necessary Covered Benefits** that are not available from **Participating Providers**.
6. **HMO** will reimburse the non-participating **Provider** at the usual and customary or an agreed upon rate, less the applicable **Copayment(s)**.

I. **Inpatient Care by Non-Primary Care Physicians, Including Hospitalists**

During an inpatient stay at a **Participating Hospital**, **Participating Skilled Nursing Facility** or other **Participating** facility, a **Participating Physician**, including a **Participating Hospitalist**, other than the **Member's PCP** may direct and oversee the **Member's** care, if the **Member's PCP** does not wish to do so and the **Member** does not object.

J. **Pre-authorization.**

Certain services and supplies under this **Certificate** may require pre-authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**.

K. **Telemedicine Medical Services and Telehealth Services.**

**HMO** will not exclude from coverage a telemedicine medical service or a telehealth service which is a **Covered Benefit** under this **Certificate** solely because the service is not provided through a face-to-face consultation.

The **Participating Health Professional** who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that

1. the informed consent of the **Member**, or another appropriate person with authority to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided; and
2. the confidentiality of the **Member's** medical information is maintained as required by law.

L. **Office of the Ombudsman**

The Office of the Ombudsman is specifically created to help **Members**, to advocate for **Members** and be a **Member's** representative and voice within the **HMO**. One of the Office of the Ombudsman's primary

concerns is to assist **Members** in understanding **HMO** plans, the coverage offered and the **Participating Providers** in these plans. The Office of the Ombudsman will also be an advocate on behalf of **Members** to assist them in obtaining **Medically Necessary Covered Benefits**. If requested, the Office of the Ombudsman can assist during internal appeals, independent review proceedings and external reviews.

The Office of the Ombudsman is not intended to replace **HMO's** member services department. The Office of the Ombudsman cannot help expedite a claim or make **Medical Necessity** or coverage decisions. If a **Member** has basic questions (information about benefits, whether a **Provider** is still a **Participating Provider**, how to obtain a new ID card, etc.), the **Member** should always begin by calling the member services toll-free number on the ID card.

The Office of the Ombudsman can give **Members** helpful information about the **HMO** processes. **Members** who need help understanding how their plan works, may call the Office of the Ombudsman for assistance.

## **ELIGIBILITY AND ENROLLMENT**

### **A. Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:
  - a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and
  - b. live or work in the **Service Area**.
2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers** and the dependent must be
  - a. the spouse of a **Subscriber** under this **Certificate**; or
  - b. a dependent unmarried child (including a natural, foster, step, or legally adopted child, a proposed adoptive child, and a child under court order) or any such child who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits; or
  - c. a dependent unmarried grandchild who is living with and in the household of the **Subscriber**.
  - d. a child who is 25 years of age or older and a full-time student at an educational institution.

In addition,

  - the dependent's legal residence must be the same as the **Subscriber's**; or
  - if the dependent's legal residence is not the same as the **Subscriber's**, the dependent must live in the **Service Area** (except in the case of a qualified medical support order). A dependent unmarried grandchild must have the same legal residence as the **Subscriber**.
3. A **Member** who resides outside the **Service Area** is required to choose a **PCP** and return to the **Service Area** for **Covered Benefits**. The only services covered outside the **Service Area** are **Emergency Services** and **Urgent Care**.

### **B. Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services. Submission of complete enrollment information and **Premium** payment to **HMO** must be made within 31 days from the eligibility date. **HMO** will not refuse to enroll an otherwise eligible person solely because the person is enrolled in another health benefit plan at the time he or she applies for **HMO** coverage.

1. Newly Eligible Individuals and Eligible Dependents.

An eligible individual and any eligible dependents who are eligible may enroll.
2. **Open Enrollment Period.**

Eligible individuals or any dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

a. Newborn Children.

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in **HMO** and any required additional **Premium** must be received by **HMO** within the initial 31 day period. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

The coverage for newly born adopted children and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

If the dependent child is born outside the **Service Area** due to a **Medical Emergency**, or in a non-participating **Hospital** to a mother who is not a **Member**, the newborn child may receive **Medical Services** from non-participating **Providers**. The newborn must be transferred to a **Participating** facility at the **HMO's** expense and, if applicable, to a **Participating Provider** when such transfer is medically appropriate as determined by the newborn's treating **Physician**.

b. Adopted Children.

A legally adopted child, a child for whom a **Subscriber** is a court-appointed legal guardian, or a child for whom the **Subscriber** is a party in a suit in which the adoption of the child by the **Subscriber** is sought, and who meets the definition of a **Covered Dependent**, will be treated as a dependent. The **Subscriber** must make a written request for coverage within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption.

4. Special Rules Which Apply to Children.

a. Qualified Medical Child Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child. The coverage shall be comparable to the coverage provided to other **Covered Dependents**. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

b. Handicapped Children.

Coverage is available for a child of any age who is medically certified as disabled and dependent upon the **Subscriber** for support and maintenance. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child is medically certified as disabled or upon request by **HMO**, whichever occurs first. Subsequent proof may be requested by the **HMO**, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such coverage. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**, unless a different notification process is agreed to between **HMO** and **Contract Holder**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **Certificate**.

An eligible individual and any eligible dependents may be enrolled, if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption.

**Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:**

An eligible individual or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c and d are met:

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;
- b. the eligible individual or the eligible dependent declines coverage in writing under **HMO**;
- c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 of the following reasons:
  - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted;
  - ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated;
  - iii. the eligible dependent is a child of the **Subscriber** and was covered under the Medicaid program (other than coverage consisting solely of pediatric vaccine program benefits); or
  - iv. the eligible dependent is a child of the **Subscriber** and was covered under the Child Health Plan (Chapter 62 of the Texas Health and Safety Code).

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **Certificate**; and

- d. the eligible individual or the eligible dependent enrolls within 31 days of the loss.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

**Special Enrollment Period When a New Eligible Dependent is Acquired:**

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement** and the Termination of Coverage section of this **Certificate**. In the event of an increase in **Premiums** effecting this **Coverage**, **HMO** will notify the **Contract Holder** and the **Member** within 60 or more days of such increase.

**Hospital Confinement on Effective Date of Coverage.**

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a **Covered Benefit** under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

### **MEDICALLY NECESSARY COVERED BENEFITS**

A **Member** shall be entitled to the **Medically Necessary Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**.

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THE SECTION OF THIS **CERTIFICATE** ENTITLED “EXCLUSIONS AND LIMITATIONS”.

The determination of **Medically Necessary** care is an analytical process applied on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case-specific information necessary to make these decisions. The determination of whether proposed care is a **Covered Benefit** is independent of, and should not be confused with, the determination of whether proposed care is **Medically Necessary**.

**HMO** will not use any decision-making process that operates to deny **Medically Necessary** care that is a **Covered Benefit** under this **Certificate**. Since **HMO** has ultimate authority to determine **Medical Necessity** for purposes of this **Certificate**, a determination under this **Certificate** that a proposed course of treatment, health care service or supply is not **Medically Necessary** may be made by **Physicians** other than the **Member’s Provider**.

This means that, even if the **Member’s Provider** determines in his or her clinical judgment that a treatment, service or supply is necessary for the **Member**, **HMO** may determine that it is not **Medically Necessary** under this **Certificate**.

In determining if a service or supply is **Medically Necessary**, **HMO’s** patient management medical director or its **Physician** designee will consider:

- the applicable standard of care;
- the opinion of the treating **Physicians**, which have credence but do not overrule contrary opinions;
- information provided on the **Member's** health status;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- **HMO's** Coverage Policy Bulletins and other non-case specific materials, which shall be based on **Medical and Scientific Evidence**; and
- any other relevant information brought to **HMO's** attention.

If a **Member** has questions regarding **Medically Necessary Covered Benefits** under this **Certificate**, the **Member** may call the Member Services toll-free telephone number listed on the **Member’s** identification card. Adverse medical necessity determinations may be appealed as described in the section of this **Certificate** entitled “Complaint Procedure,” including the ability to appeal to an independent review organization.

**THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS AND DEDUCTIBLES LISTED ON THE SCHEDULE OF BENEFITS.**

**EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP’S OFFICE THAT IS SHOWN ON THE MEMBER’S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER’S PCP.**



A. **Primary Care Physician Benefits.**

1. Office visits during office hours.
2. Home visits
3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:
  - a. call the **PCP's** office;
  - b. identify himself or herself as a **Member**; and
  - c. follow the **PCP's** or covering **Physician's** instructions.

If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care Benefits section of this **Certificate**.

4. **Hospital** visits.
5. Periodic health evaluations to include:
  - a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus influenza type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; rotavirus; and varicella, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law.
  - b. routine physical examinations.
  - c. routine gynecological examinations, including Pap smears, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and Pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.
  - d. routine speech and hearing screenings.
  - e. immunizations (but not if solely for the purpose of travel or employment).
  - f. routine vision screenings.
6. Injections, including allergy desensitization injections.
7. Casts and dressings.
8. Health Education Counseling and Information.

B. **Diagnostic Services Benefits.**

Services include, but are not limited to, the following:

1. Diagnostic laboratory and imaging services, including x-rays.

2. Mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain pre-authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 and older, 1 routine mammography every year; or
- when **Medically Necessary**.

3. prostate cancer screening, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from his **PCP**, or obtain pre-authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Prostate cancer screening benefits for male **Members** are provided as follows:

- age 40-49, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year, if the **Member** is at an increased risk of developing prostate cancer as determined by his **Physician**; or
- age 50 and older, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year;

4. **Osteoporosis Benefits.** Bone mass measurement by a **Participating Provider** to determine a **Qualified Individual's** risk of osteoporosis and fractures associated with osteoporosis is covered. The **Member** is required to obtain a **Referral** from his or her **PCP**, or obtain pre-authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

5. **Newborn Hearing Screening, Diagnosis and Treatment**

- A screening test to determine hearing loss is covered for a newborn child from birth through the date the child is 30 days old.
- **Medically Necessary** diagnosis and treatment is covered for **Members** from birth through the date the child is 2 years old.

C. **Specialist Physician Benefits.**

**Covered Benefits** include outpatient and inpatient services.

If a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. If **PCP** in consultation with an **HMO** Medical Director and an appropriate **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to a **Specialist**. This standing **Referral** shall be pursuant to a treatment plan approved by the **HMO** Medical Director in consultation with the **PCP**, **Specialist** and **Member**.

**Member** may request a second opinion regarding a proposed surgery or course of treatment recommended by **Member's PCP** or a **Specialist**. Second opinions may be obtained on referral from the **Member's PCP**. Requests for second opinions from non-participating **Providers** must be pre-authorized.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear (s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Direct Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. Direct access includes care related to pregnancy; care for all active gynecological conditions; and diagnosis, treatment and **Referral** for any disease or condition which is within the scope of the professional OB/GYN practice.

E. **Maternity Care and Related Newborn Care Benefits.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are **Covered Benefits**. The **Participating Provider** is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from **HMO** after the first pre-natal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives pre-authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for inpatient services only at **Participating Hospitals** and **Participating Skilled Nursing Facilities**. All inpatient services are subject to pre-authorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** medical director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital, Skilled Nursing Facility, Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

The following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a **Physician**, registered nurse, or other appropriate licensed health care **Provider** and may be provided at the mother's home, a health care **Provider's** office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A **Copayment** will not apply for home health care visits.

The following coverage is provided for a **Member** following a mastectomy:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a mastectomy;
2. a minimum of 24 hours of inpatient care in a **Participating Hospital** following a lymph node dissection for the treatment of breast cancer.

A **Member** may request a shorter length of stay if the **Member's Participating Provider** determines the shorter stay to be appropriate.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Inpatient **Hospital** cardiac and pulmonary rehabilitation services are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorization by **HMO**.

**G. Transplant Benefits.**

A transplant is a **Covered Benefit** when **HMO** has determined that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Covered transplants must be ordered by the **Member's PCP** or **Participating Specialist Physician** and approved by **HMO's** medical director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. The **Member** will not be required to travel out-of-state to receive transplant services unless the **HMO** obtains the informed consent of the **Member**.

If **HMO** denies coverage of a transplant based on lack of **Medical Necessity**, the **Member** may request a review by an independent review organization (IRO), as described in the Complaint Procedure section of this **Certificate**. If **HMO** denies coverage of a transplant based on the transplant being an **Experimental or Investigational Procedure**, the **Member** may request an **External Review**, as described in the Complaint Procedure section of this **Certificate**.

**H. Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to pre-authorization by **HMO**.

**I. Chemical Dependency Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification** and treatment of **Chemical Dependency**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or a controlled substance.
2. Inpatient care benefits in a **Participating Hospital** or treatment facility that is a **Participating Provider** are covered for the medical complications and treatment of **Chemical Dependency** and **Detoxification**. Benefits include medical treatment and referral services for **Chemical Dependency** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physician**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

**J. Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** as defined in the Definitions section of the **Certificate** and provided through **Participating Behavioral**

## **Health Providers.**

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. **Benefits for Serious Mental Illness**

Inpatient care received in a **Participating Hospital** or **Participating Mental Health Treatment Facility** for the **Medically Necessary** care, diagnosis and treatment of a **Serious Mental Illness** while the **Member** is a full-time inpatient is covered. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

One (1) inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization**, Residential Treatment Center and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation.

Outpatient care received from a **Participating Provider** for the **Medically Necessary** care, diagnosis and treatment of a **Serious Mental Illness** is covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Any outpatient visits for the purpose of medication management will not be counted toward the maximum number of visits, but visits for medication management will be under the same terms and conditions as for outpatient visits for treatment of physical illness generally.

Coverage for **Serious Mental Illness** will include the same **Copayments** as for any other physical illness.

## **K. Emergency Care Benefits.**

A **Member** is covered for **Emergency Services**.

Benefits include:

1. a medical screening examination/evaluation, in accordance with any state or federal law, the purpose of which is to determine whether a **Medical Emergency** exists;
2. the treatment and stabilization of the **Member** for a **Medical Emergency**;
3. post-stabilization services originating in a **Hospital** emergency facility or comparable facility following treatment or stabilization of a **Medical Emergency**, as approved by **HMO**. In addition, the **HMO** reserves the right to approve or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request.

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply if the **Member** is admitted into the **Hospital** at the time of the emergency room visit. Instead, the **Member** will be responsible for the applicable inpatient **Copayment**, if any.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**.

In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**.

Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

In determining whether services provided to a **Member** will be covered as **Emergency Services**, **HMO** has the right to review the services and the circumstances in which the **Member** received them.

- If the **Member's** condition is a **Medical Emergency**, **HMO** will cover the medical screening examination, evaluation, stabilization and treatment.
- If the **Member's** condition is not is a **Medical Emergency**, **HMO** will cover only the medical screening examination and evaluation.
- If the **Member** wishes to appeal a denial or reduction of payment for **Emergency Services** based on failure to meet the prudent layperson standard, the **Member** may appeal under the process described in Section D of "**Complaint Procedures**".

#### L. **Urgent Care Benefits**

- **Urgent Care Within the HMO Service Area.** If the **Member** needs **Urgent Care** while within the **HMO Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's Primary Care Physician**. If the **Member's Primary Care Physician** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care** facility within the **HMO Service Area**.
- **Urgent Care Outside the HMO Service Area.** The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **HMO Service Area** if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**.

A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for care which is provided to a **Member** after the **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

#### M. **Outpatient Rehabilitation Benefits.**

A **Member** is covered for rehabilitative services and physical, speech and occupational therapies rendered by a **Participating Provider** that, in the opinion of a **Participating Physician**, are **Medically Necessary**. Services and therapies may not be denied, limited or terminated if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

A **Member** is also covered for the following which result from and are related to an acquired brain injury:

1. Cognitive rehabilitation therapy;

2. Cognitive communication therapy;
3. Neurocognitive therapy and rehabilitation;
4. Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
5. Neurofeedback therapy;
6. Remediation;
7. Post-acute transition services; or
8. Community reintegration services.

**N. Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Pre-authorization must be obtained from the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.
3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Short-term physical, speech, or occupational therapy is covered. Coverage is limited to those conditions and services under the **Outpatient Rehabilitation Benefits** section of this **Certificate**.

Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

**O. Hospice Benefits.**

**Hospice Care** services for a terminally ill **Member** are covered when pre-authorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling and financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other members of the family, transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

**P. Prosthetic Appliances Benefits.**

The **Member's** initial provision and replacement of a prosthetic device, including a breast prosthesis, that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of

disease or injury or congenital defects is a **Covered Benefit**, when such device is prescribed by a **Participating Provider**, administered through a **Participating** or designated prosthetic **Provider** and pre-authorized by **HMO**. The **Covered Benefit** includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are **Covered Benefits**. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**.

**Q. Injectable Medications Benefits.**

Injectable medications, including those medications intended to be self-administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medications are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in 1 of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least 1 study published in a nationally recognized peer reviewed journal.

**R. Reconstructive Breast Surgery Benefits.**

Reconstructive breast surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including areolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and treatment of physical complications of mastectomy, including lymphedemas.

**S. Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when pre-authorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ. For purposes of this benefit, the temporomandibular joint includes the jaw and the craniomandibular joint.

**T. Diabetes Related Benefits.**

Benefits for the treatment of diabetes and associated conditions. Coverage includes diabetes equipment, diabetes supplies and diabetes self-management training. All provisions applicable to other illness and surgical treatment, including **Copayments**, will apply to benefits for diabetes related coverage.

**U. Additional Benefits.**

- **Infertility Services Benefits.**

**Infertility** services are covered upon pre-authorization by **HMO** when provided by a **Participating Provider**. Benefits include those services to diagnosis and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

- **Treatment of Phenylketonuria or Other Heritable Diseases.**



Coverage is provided for formulas necessary for the treatment of **Phenylketonuria** or other **Heritable Diseases** to the same extent as for drugs available only on the orders of a **Physician**.

- **Colorectal Cancer Screening.**

For **Members** who are age 50 and older and at normal risk for developing colon cancer are provided as follows:

1. a fecal occult blood test every year; and
2. a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years.

- **Experimental and Investigational Procedures and Clinical Trials.**

Coverage is provided for **Experimental or Investigational Procedures** and clinical trials for a **Member** who is eligible according to the provisions of this section.

To be covered, the **Member's Physician** must state in writing that the **Member** has a current diagnosis which has a probability of causing death in two years or less and for which standard therapies have not been effective in significantly improving the condition of the **Member** or for which standard therapies would not be medically appropriate.

In addition, one of the following two criteria must be met:

- A. The proposed treatment is likely to be more beneficial to the **Member** than available standard therapies, based on two documents of **Medical and Scientific Evidence** identified in the **Physician's** statement; or
- B. The **Member** is to be treated as part of a clinical trial satisfying all of the following criteria:
  - the investigational drug, device, therapy or procedure is under current review by the FDA and has been determined to be safe for human use; and
  - the clinical trial has been approved by an Institutional Review Board (IRB) that will oversee the investigation; and
  - the clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials.

**Copayments** may apply to services and supplies received during coverage for a clinical trial. Refer to the Schedule of Benefits attached to this **Certificate** for specific **Copayments** that may apply. For example, if a **Member** completes a **Specialist Physician** office visit during the course of the clinical trial, the plan **Specialist Physician Copayment** shown in the Schedule of Benefits may apply.

- **Therapeutic Radiology Services.**

Coverage is provided for the treatment of disease by therapeutic radiology, including: evaluation and consultation; clinical treatment planning; treatment setup; clinical treatment management and post treatment follow-up.

- **Craniofacial Abnormality Benefits.**

Coverage is provided for treatment of an abnormal structure or deformity of the cranial and facial bones caused by congenital defects, developmental deformities, trauma, tumors, infections or

disease, including a defect of the upper face or midface, a defect of the midface or lower face, or both.

- **Anesthesia Benefits for Certain Dental Procedures.**

For **Members** unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the **Member's Physician** or the dentist providing the dental care. This benefit does not require **HMO** to provide dental services as otherwise excluded in the **Exclusions and Limitations** section of this **Certificate**.

- **Complications of Pregnancy.**

Including conditions that require a **Hospital** stay during the term of the pregnancy and which are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This does not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy; or (2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

## **EXCLUSIONS AND LIMITATIONS**

### **Exclusions**

The following are not **Covered Benefits** unless described in rider(s) or amendment(s) attached to this **Certificate**:

- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury. Examples include asbestos removal, air filtration, and special ramps or doorways.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** medical director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed. This exclusion also does not apply to reconstructive surgery performed on a **Member** who is less than 18 years of age to improve the function of or to attempt to create a normal appearance of a **Craniofacial Abnormality**.
- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation, vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. Dental services and supplies for treatment of temporomandibular joint (TMJ) dysfunction except for diagnostic and medical/surgical treatment of TMJ. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts. This exclusion does not apply to **Medical Services** required for the delivery of necessary and appropriate dental services

when the dental services cannot be safely provided in a dentist's office due to the **Member's** physical, mental or medical condition.

- **Durable Medical Equipment, except for those items necessary for the treatment of diabetes.**
- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- **Experimental or Investigational Procedures** or ineffective surgical, medical, psychiatric or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless pre-authorized by **HMO**.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Hair analysis.
  - Health services, specifically charges for health services, incurred before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**. This exclusion does not apply to covered services resulting from complications of pregnancy incurred after the **Member's Effective Date of Coverage**.
  - Hearing aids.
  - Home births.
  - Home uterine activity monitoring.
  - Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
  - Hypnotherapy, except when pre-authorized by **HMO**.
  - Implantable drugs.
  - Infertility Services including but not limited to:
    1. Artificial insemination; ovulation induction.

2. Infertility Services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
  3. Reversal of sterilization surgery;
  4. Infertility Services for female Members with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
  5. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
  6. Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
  7. Home ovulation prediction kits;
  8. Drugs related to the treatment of non-covered benefits or related to the treatment of Infertility that are not Medically Necessary;
  9. Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
  10. Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”);
  11. Any charges associated with care required to obtain ART Services (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.
- Inpatient care for **Serious Mental Illness** which is not provided in a **Hospital** or **Mental Health Treatment Facility**; non-medical ancillary services and rehabilitation services in excess of the number of days described in the Schedule of Benefits for **Serious Mental Illness**.
  - Inpatient treatment for **Mental or Behavioral Conditions** that are not **Serious Mental Illness**, unless this benefit is covered by a rider attached to this **Certificate**.
  - Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
  - Missed appointment charges.
  - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
  - Orthotics.
  - Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips, except that this exclusion does not apply to diabetes supplies.

- Payment for that portion of the benefit for which Medicare or another party is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis, unless covered by a prescription drug rider. This exclusion does not apply to diabetes supplies.
- Private duty or special nursing care, unless pre-authorized by **HMO**.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services or supplies as follows:
  1. services or supplies that do not require the technical skills of a medical, mental health or a dental professional;
  2. services or supplies furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  3. services or supplies furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and effectively be diagnosed or treated while not confined;
  4. services or supplies furnished in a particular setting that could safely and effectively be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Spinal manipulation for subluxation.
- Services rendered for the treatment of delays in speech development, when there is no underlying medical cause, such as that resulting from disease, injury, or congenital defects, are not covered.
- Thermograms and thermography. (Thermography is the measurement of temperature variations at the body surface.)
- Therapy or rehabilitation as follows: primal therapy (intense non-verbal expression of emotion expected to result in improvement or cure of psychological symptoms), chelation therapy (removal of excessive heavy metal ions from the body), rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, carbon dioxide and other therapy or rehabilitation not supported by Medical and Scientific Evidence. This exclusion does not apply to rehabilitative services such as physical, speech and occupational therapy.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a workers' compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.
- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **Morbid Obesity**, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.

## **TERMINATION OF COVERAGE**

A **Member's** coverage under this **Certificate** will terminate upon the earliest of any of the conditions listed below, and termination will be effective on the date indicated on the Schedule of Benefits.

### **A. Termination of Subscriber Coverage.**

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;
2. the **Group Agreement** terminates;
3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or on the Schedule of Benefits; or
4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

### **B. Termination of Dependent Coverage.**

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined in this **Certificate** and/or on the Schedule of Benefits;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates.

### **C. Termination For Cause.**

**HMO** may terminate coverage for cause:

1. upon 30 days advance written notice, if the **Member** is unable to establish a satisfactory physician-patient relationship with a **Participating Provider**. This is subsequent to the **HMO**, in good faith, having provided the **Member** the opportunity to select an alternative **Participating Provider**, and the **Member** is notified in writing at least 30 days in advance that **HMO** considers the physician-patient relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the **Member** has failed to make such changes. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to the **Contract Holder**.
2. upon 30 days advance written notice, if the **Member** has failed to make any required **Copayment** or other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.
3. upon 15 days advance written notice, upon discovery of an intentional misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or upon discovery of the **Member's** commission of fraud against **HMO**, including fraud in the use of services or facilities. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits.



4. immediately, for misconduct detrimental to safe plan operations and the delivery of services.
5. immediately, for failure to meet eligibility requirements other than the requirement that the **Subscriber** live or work in the **Service Area**.
6. upon 30 days advance written notice, if the **Subscriber** does not live or work in the **Service Area**. Such termination will be made uniformly without regard to any health status-related factor. Coverage for a child who is the subject of a medical support order will not be cancelled solely because the child does not live or work in the **Service Area**.

A **Member** may request that **HMO** conduct a **Complaint** hearing, as described in the Complaint Procedure section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the **Complaint** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not requested a **Complaint** hearing, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will refund any **Premiums** paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's Complaint** procedure to register a **Complaint** against **HMO**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this **Certificate**.

Upon 30 days written notice to the **HMO**, the **Member** may terminate their enrollment in the **HMO** in the case of a material change by the **HMO** to any provisions required to be disclosed to the **Members** pursuant to state law.

**HMO** shall have no liability or responsibility under this **Certificate** for services provided on or after the date of termination of coverage.

#### **Termination of Group Agreement.**

**HMO** may terminate or non-renew the **Group Agreement** if:

1. **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Group Agreement** within the grace period. **HMO** may terminate this **Group Agreement** as of the last day for which **Premiums** were received, subject to the **Grace Period**. In the event of such termination, the **Member** will be responsible for the cost of services received during the **Grace Period**;
2. upon 15 days written notice, the **Contract Holder** has performed an act or practice that constitutes fraud or intentional misrepresentation of a material fact in obtaining coverage under this **Group Agreement**;
3. the **Contract Holder** has failed to comply with any employer contribution or group participation rules, **HMO** may terminate this **Group Agreement** in accordance with state law;
4. upon 180 days written notice, **HMO** ceases to offer coverage in the market in accordance with state law;
5. upon 90 days written notice, **HMO** ceases to offer coverage of a specific product in the market in accordance with state law;
6. upon 30 days written notice, the **Contract Holder** no longer has any enrollee under the plan who lives, resides, or works in the **Service Area**

7. upon 30 days written notice, the **Contract Holder's** membership in the association, through which coverage is obtained, ceases.

**Contract Holder** may terminate the **Group Agreement**, upon 30 days written notice to the **HMO**, if **HMO** makes a material change to any provision required by law to be disclosed to **Contract Holder** or **Members**.

The fact that **Members** are not notified by the **Contract Holder** of the termination of their coverage due to the termination of the **Group Agreement** shall not continue the **Members'** coverage beyond the date coverage terminates.

## CONTINUATION AND CONVERSION

### A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and related amendments ("COBRA"). The description of COBRA which follows is intended only to summarize the **Member's** rights under the law. Coverage provided under this **Certificate** offers no greater COBRA rights than COBRA requires and should be construed accordingly. COBRA permits eligible **Members** or eligible **Covered Dependents** to elect to continue group coverage as follows:

**Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA; however, they may be eligible for continuation of coverage as provided by subsection B., of this section, Continuation of Coverage - State of Texas.**

1. Minimum Size of Group:

The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

**Member** may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

- a. divorce or legal separation, or
- b. **Subscriber's** death, or
- c. **Subscriber's** entitlement to Medicare benefits, or,
- d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

- a. the last day of the 18-month period.
- b. the last day of the 36-month period.
- c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.
- d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
- e. the first day, after the day COBRA coverage has been elected, on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for

a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

- f. the date, after COBRA coverage has been elected, when the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

- a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.
- b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** within 60 days of the Social Security determination and before the end of the initial 18-month period, continuation coverage for the **Member** and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The **Member** must have become disabled during the first 60 days of the COBRA continuation coverage.

6. Responsibility of the **Contract Holder** to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period, as required by COBRA.

7. Responsibility to pay **Premiums** to **HMO**:

The **Subscriber** or **Member** will only have coverage for the 60 day initial enrollment period if the **Subscriber** or **Member** pays the applicable **Premium** charges due within 45 days of submitting the application to the **Contract Holder**.

- 8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage - State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

- a. the death of the **Subscriber**;
- b. the retirement of the **Subscriber**; or
- c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the

right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;
- b. the end of the 3 year period after the date of the divorce or legal separation;
- c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or
- d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. Group Continuation Privilege.

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination, shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder** within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. six months after the date the election is made;
- b. the date on which failure to make timely payments would terminate coverage;
- c. the date on which the group coverage terminates in its entirety;
- d. the date on which the **Member** is or could be covered under Medicare;
- e. the date on which the **Member** is covered for similar benefits by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;
- f. the date the **Member** is eligible for similar benefits whether or not covered therefore under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

C. **Conversion Privilege.**

A conversion health care coverage agreement (conversion coverage) is not available under this **Group Agreement**. No conversion privilege is granted under this **Group Agreement**.

D. **Extension of Benefits While Member is Receiving Inpatient Care.**

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay; or
2. determination by the **HMO** medical director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached; or
4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or
5. 12 months of coverage under this extension of benefits provision.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

E. **Texas Health Insurance Risk Pool.**

A **Member** may be eligible for coverage under the Texas Health Insurance Risk Pool. Prior to the end of the **Member's** coverage under the "Continuation of Coverage - State of Texas" section of this **Certificate**, **HMO** will provide the **Member** with the Texas Health Insurance Risk Pool's address and toll-free telephone number.

## **COMPLAINT PROCEDURE**

In situations when **Members** are dissatisfied with HMO services, the following procedures govern **Complaints** and **Complaint** appeals made or submitted by or on behalf of **Members**.

### **A. Definitions.**

1. An “inquiry” is a **Member’s** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided. It may also be a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the **Member**.
2. An “**Adverse Determination**” is a determination that a service or supply is not **Medically Necessary** or appropriate.
3. A “**Complaint**” is any dissatisfaction expressed by a **Member** orally or in writing to **HMO** with any aspect of **HMO’s** operation, including but not limited to:
  - a. dissatisfaction with plan administration;
  - b. procedures related to review or appeal of an adverse determination;
  - c. the denial, reduction, or termination of a service for reasons not related to **Medical Necessity** or appropriateness;
  - d. the way a service is provided; or
  - e. disenrollment decisions.

A **Complaint** does not include a **Provider’s** or **Member’s** dissatisfaction or disagreement with an **Adverse Determination**.

### **B. Complaint Review.**

1. **HMO** will send the **Member** acknowledgment of the **Complaint** within 5 business days of having received it. The acknowledgment will contain:
  - a. the date of receipt of the **Complaint**;
  - b. a description of **HMO’s Complaint** procedures and time frames;
  - c. a one-page **Complaint** form, clearly stating that the **Complaint** form must be returned to **HMO** for prompt resolution of the **Complaint**, if the **Complaint** is received orally;
  - d. requests for the **Member** to provide any additional information, including necessary documentation, to assist **HMO** in handling and deciding the **Complaint**; and
  - e. a notice informing the **Member** of the **Member’s** right to have an uninvolved **HMO** representative assist the **Member** in understanding the **Complaint** process.

**HMO** will acknowledge, investigate, and resolve the **Complaints** within 30 calendar days from the date of receipt of the written **Complaint** or one-page **Complaint** form.

2. The **Complaint** Panel reviewing the **Complaint** shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the **Complaint**.
3. A written notice stating the result of the review by the **Complaint** Panel shall be forwarded by **HMO** to the **Member**. Such notice shall include:
  - a. a description of the Panel's understanding of the **Member's Complaint** as presented to the **Complaint** Panel (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and
  - b. the Panel's decision in clear terms, including the contract basis or rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and
  - c. citations to the evidence or documentation used as the basis for the decision, including the specialization of any **Provider** consulted (i.e., reference to the **Certificate**, medical records, etc.);
  - d. a full description of the **Complaint** appeals process, the time frames for the final decision on the appeal and the right to obtain assistance from **HMO's** Office of the Ombudsman.
4. If **Subscriber's** health plan is governed by the Employee Retirement Income Security Act (ERISA), the **Member** has the right to bring civil action under 502(a) of ERISA.

**C. Complaint Appeals.**

1. Upon receipt of a **Member's** written appeal of a **Complaint**, **HMO** shall provide the **Member** with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the **Member** to appear before the Appeal Panel. The appeal process gives the **Member** the opportunity to appear in person or by telephone before the Appeal Panel or address the **Member's** issues through a written appeal to the Appeal Panel. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

No less than 5 business days prior to the **Member's** appearing before the Appeal Panel, the **Member** will receive a copy of any documentation to be presented by the **HMO** staff; the specialization of Physicians or **Providers** consulted during the review; and the name and affiliation of all **HMO** representatives on the Appeal Panel. The **Member** may respond to this information for the Appeal Panel to consider in the **HMO's** deliberations.
2. The Appeal Panel shall be comprised of equal numbers of non-employee **HMO Members**; **HMO** staff persons not previously involved in the disputed decision; and **Physicians** or **Providers** experienced in the area of care that is in dispute and who are independent of the **Physicians** or **Providers** who made the prior decision that resulted in the **Member's** appeal. If specialty care is in dispute, the appeal panel shall include a person who is a **Specialist** in the field of care to which the appeal relates.
3. The Appeal Panel shall hold appeal hearings within the **Member's** county of residence or the county where the **Member** normally receives the **HMO's** health care services. Another location may be used if in agreement by the **Member** and **HMO**.



4. The **Member** shall have the right to attend the appeal hearing in person or by telephone, question the representative of **HMO** designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their **Complaint**. A guest may accompany the **Member**, but the guest cannot participate in the hearing unless the **Member** is a minor or disabled, then a guest may represent the **Member**. Guests include a **Member's** friend, attorney or relative. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. The Appeal Panel shall have the right to question the **HMO** representative, the **Member** and any other witnesses.
5. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing.
6. **HMO** shall make a written record of the appeal hearing.
7. Before the record is closed, the Chair of the Appeal Panel shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.
8. The Appeal Panel shall render a written decision within 30 calendar days following receipt of the appeal. The decision shall contain:
  - a. date of receipt of the oral or written request for appeal;
  - b. a statement of the Appeal Panel's understanding of the nature of the **Complaint** and the material facts related thereto;
  - c. the Appeal Panel's decision and rationale, including a statement of the specific determination, clinical basis, and contractual criteria used to reach the final decision;
  - d. a summary of the evidence, including necessary document supporting the decision; and
  - e. a statement of the **Member's** right to appeal to the Department of Insurance, with the following toll-free telephone number and complete address of the Department of Insurance:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714 - 9104  
1-800-252-3439
9. Upon request and free of charge, the **Member** or the **Member's** designee is provided reasonable access to, and copies of all documents, records and other information relevant to the claim or appeal involving a benefit determination, including:
  - those relied upon in making the benefit determination;
  - those submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
  - those demonstrating compliance with the administrative processes and safeguards used in making the benefit determination; and

- those which are a statement of policy or guidance with respect to the **Certificate** concerning the denied treatment option or benefit for the **Member's** diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**D. Adverse Determinations.**

In the event of an **Adverse Determination**, **HMO** shall notify the **Member** or a person acting on behalf of the **Member** and the **Member's** provider of record of an **Adverse Determination**.

The notification shall include the following:

- the principal reasons for the **Adverse Determination**;
- the clinical basis for the **Adverse Determination**;
- a description or the source of the screening criteria that were utilized as guidelines in making the determination; and
- a description of the procedure for the complaint and appeal process, including:
  - notification to the **Member** of the **Member's** right to appeal **Adverse Determination** to an independent review organization;
  - notification to the **Member** of the procedures for appealing an **Adverse Determination** to an independent review organization; and
  - notification to a **Member** who has a life-threatening condition of the **Member's** right to an immediate review by an independent review organization and the procedures to obtain that review.

**E. Adverse Determination Appeals.**

1. Any written or oral dissatisfaction or disagreement with an **Adverse Determination** from a **Member**, a person expressly authorized to act on behalf of a **Member** or a **Member's Provider** of record shall be considered an **Adverse Determination** appeal. **HMO** shall provide a letter to the party filing the appeal within 5 business days of receipt of the appeal acknowledging the date of receipt of the appeal. This letter shall describe the **Adverse Determination** appeals process and inform the **Member** of the **Member's** right to have an uninvolved **HMO** representative or **HMO's** Office of the Ombudsman assist the **Member** in understanding the appeal process. For oral appeals, the acknowledgement letter shall include a one-page appeal form for completion by the appealing party.
2. In circumstances involving a **Member** who has a life-threatening condition, the **Member**, the **Member's** authorized representative or the **Member's Physician** is entitled to an immediate appeal to an IRO (as described below) and is not required to complete **HMO's Adverse Determination** appeal process. A life-threatening condition is a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.
3. After receipt of an **Adverse Determination** appeal, **HMO** shall request from the **Member** and/or the **Providers** involved in the case any new information needed to review the **Adverse Determination**. The case will be referred for review by a **Physician** who has not previously reviewed or been involved in the case.

4. **HMO** shall make a decision on each **Adverse Determination** appeal and notify the appealing party of the outcome within 30 days of receipt of the appeal. The **Member**, the **Member's** authorized representative, the **Member's Physician** or the **Member's** other **Provider** may request an expedited review of an **Adverse Determination** appeal involving an ongoing emergency or denial of continued hospitalization stays. The expedited review will be concluded in accordance with the medical or dental immediacy of the case but no longer than 1 business day from the day the appeal (including all information necessary to complete the appeal) is received.
5. **HMO** shall notify the appealing party of the outcome of the **Adverse Determination** appeal in writing.

If the **Adverse Determination** is upheld upon appeal, the notice will include the following:

- the reason and clinical basis for the decision;
- the specialty of the reviewer(s); and
- the appealing party's right to seek review by an Independent Review Organization, as explained below.

Initial notice of the outcome of **Adverse Determination** appeals involving ongoing emergencies or denials of continued hospitalization stays may be delivered orally if followed by written notice of the determination within 3 days.

6. Upon request and free of charge, the **Member** or the **Member's** designee is provided reasonable access to, and copies of all documents, records and other information relevant to the claim or appeal involving a benefit determination, including:
  - those relied upon in making the benefit determination;
  - those submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
  - those demonstrating compliance with the administrative processes and safeguards used in making the benefit determination;
  - those which are a statement of policy or guidance with respect to the Certificate concerning the denied treatment option or benefit for the **Member's** diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

#### F. **Appeals to an Independent Review Organization (IRO).**

If a **Member** has a life-threatening condition, an immediate appeal to an IRO (as described above) may be made without first completing **HMO's Adverse Determination** appeal process.

**HMO** participates in the Texas independent review organization (IRO) process. A **Member**, a person expressly authorized to act on behalf of a **Member** and a **Member's Provider** whose **Adverse Determination** appeal is denied has the right to seek review of that determination by an IRO in accordance with state law if the **Adverse Determination** was made in connection with a *prospective* or *concurrent* review of **Medical Necessity**. *Prospective* review is performed before the **Member** would have received the treatment in question and *concurrent* review is performed at the same time the **Member** is receiving the treatment.

*Retrospective* review is a review performed for the first time after the **Member** has received the treatment in question. *Retrospective* review does not include subsequent review of services for which *prospective* or *concurrent* reviews for **Medical Necessity** and appropriateness were previously conducted. The **Member** does not have a right to an IRO review if the **Adverse Determination** was made as a result of a *retrospective* review.

The **Member** may request assistance from **HMO's** Office of the Ombudsman. Not later than the third business day after the date that **HMO** receives a request for review, **HMO** will provide to the IRO the following:

1. any medical records of the **Member** that are relevant to the review;
2. any documents used by **HMO** in making the determination;
3. the written notification of the appeal hearing decision provided to the **Member**;
4. any documentation and written information submitted to **HMO** in support of the appeal; and
5. a list of each **Provider** who has provided care to the **Member** and who may have medical records relevant to the appeal.

The IRO's determination with respect to the **Medical Necessity** or appropriateness of health care items and services for a **Member** is binding on **HMO** and **HMO** will pay for the independent review.

G. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to the establishing of any litigation, arbitration or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **Certificate** by **HMO**, or any matter within the scope of the **Complaint** and **Adverse Determination** process. The foregoing procedures and processes are not in lieu of any statutory rights **Members** may have to institute litigation, arbitration or administrative proceedings.

If **Subscriber's** health plan is governed by the Employee Retirement Income Security Act (ERISA), **Member** has the right to bring civil action under 502(a) or ERISA.

H. **Record Retention.**

**HMO** shall retain the records of all **Complaints** for a period of at least 3 years from the date of the receipt of the **Complaint**. The records will include each **Complaint** and any **Complaint** proceeding and any actions taken on a **Complaint**. A **Member** is entitled to a copy of the record on the applicable **Complaint** and any **Complaint** proceeding.

I. **Fees and Costs.**

Except for the costs associated with an independent review by an IRO, nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or appeal.

J. **HMO** may not refuse to renew or cancel coverage of the **Contract Holder** or a **Member** or take any other retaliatory action because the **Contract Holder** or a **Member** has filed a **Complaint** or appealed an **Adverse Determination**. **HMO** may not refuse to renew or terminate a contract with a **Participating Provider** or **Participating Physician** in retaliation for the filing of a **Complaint** or appeal of an **Adverse Determination** on behalf of a **Member**.

### **BINDING ARBITRATION**

**HMO, Contract Holder** and **Member** may agree to binding arbitration to resolve any controversy, dispute or claim between them arising out of or relating to this **Certificate**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). Said binding arbitration shall be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If administrator declines to oversee the case and the parties do not agree on an alternative administrator, a sole neutral Arbitrator shall be appointed upon petition to a court having jurisdiction. Should the parties agree to resolve their controversy, dispute or claim through binding arbitration, said arbitration shall be held in lieu of any and all other legal remedies and rights that the parties may have regarding their controversy, dispute or claim, unless otherwise required by law.

If the parties do not agree to binding arbitration, nothing herein shall limit any legal right or remedy that the parties may otherwise have.

## COORDINATION OF BENEFITS

**Definitions.** When used in this provision, the following words and phrases have the following meaning:

**Allowable Expense.** A health care service or expense, including coinsurance and **Copayments**, that is covered at least in part by any of the **Plans** covering the **Member**. When a **Plan** provides benefits in the form of services the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. This **Plan** limits coordination of healthcare services or expenses with those services or expenses that are covered under similar types of **Plans**, e.g. coordination with Medical/Pharmacy coverage is coordinated with Medical/Pharmacy **Plans**. An expense or service that is not covered by any of the **Plans** is not an **Allowable Expense**. The following are examples of expenses and services that are not **Allowable Expenses**:

1. If a **Member** is confined in a private **Hospital** room, the difference between the cost of a semi-private room in the **Hospital** and the private room (unless the **Member's** stay in the private **Hospital** room is **Medically Necessary** in terms of generally accepted medical practice, or one of the **Plans** routinely provides coverage of **Hospital** private rooms) is not an **Allowable Expense**.
2. If a **Member** is covered by 2 or more **Plans** that compute their benefit payments on the basis of **Reasonable Charge**, any amount in excess of the highest of the **Reasonable Charges** for a specific benefit is not an **Allowable Expense**.
3. If a **Member** is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**, unless the **Secondary Plan's** provider's contract prohibits any billing in excess of the provider's agreed upon rates.
4. The amount a benefit is reduced by the **Primary Plan** because a **Member** does not comply with the **Plan** provisions. Examples of these provisions are second surgical opinions, pre-authorization of admissions, and preferred provider arrangements.

If a **Member** is covered by 1 **Plan** that calculates its benefits or services on the basis of **Reasonable Charges** and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary Plan's** payment arrangements shall be the **Allowable Expense** for all the **Plans**.

**Claim Determination Period(s).** Usually, the calendar year.

**Closed Panel Plan(s).** A **Plan** that provides health benefits to **Members** primarily in the form of services through a panel of **Providers** that have contracted with or are employed by the **Plan**, and that limits or excludes benefits for services provided by other **Providers**, except in cases of **Emergency Services** or **Referral** by a panel **Provider**.

**Coordination of Benefits (COB).** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Medicare.** The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes **HMO** or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

**Plan(s).** Any **Plan** providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;
4. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
6. **Medicare** or other governmental benefits;
7. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

If the **Plan** includes both medical and dental coverage, those coverages will be considered separate **Plans**. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy **Plans**. In turn, the dental coverage will be coordinated with other dental **Plans**.

**Plan Expenses.** Any necessary and reasonable health expenses, part or all of which are covered under this **Plan**.

**Primary Plan/Secondary Plan.** The order of benefit determination rules state whether coverage under this **Certificate** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the **Member**.

When coverage under this **Certificate** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan**’s benefits.

When coverage under this **Certificate** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan**’s benefits.

When there are more than 2 **Plans** covering the person, coverage under this **Certificate** may be a **Primary Plan** as to 1 or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan(s)**.

This **Coordination of Benefits (COB)** provision applies to this **Certificate** when a **Subscriber** or the **Covered Dependent** has medical and/or dental coverage under more than 1 **Plan**.

The Order of Benefit Determination Rules below determines which **Plan** will pay as the **Primary Plan**. The **Primary Plan** pays first without regard to the possibility that another **Plan** may cover some expenses. A **Secondary Plan** pays after the **Primary Plan** and may reduce the benefits it pays.

#### **Order of Benefit Determination.**

When 2 or more **Plans** pay benefits, the rules for determining the order of payment are as follows:

- A. The **Primary Plan** pays or provides its benefits as if the **Secondary Plan(s)** did not exist.
- B. A **Plan** that does not contain a **COB** provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **Plan** provided by the **Contract Holder**. Examples of this type of exception are major medical coverages that are superimposed over base **Plans** providing **Hospital** and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.

- C. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.
- D. The first of the following rules that describes which **Plan** pays its benefits before another **Plan** is the rule which will govern:
1. **Non-Dependent or Dependent.** The **Plan** that covers the person other than as a dependent, for example as an employee, **Subscriber** or retiree is primary and the **Plan** that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the 2 **Plans** is reversed so that the **Plan** covering the person as an employee, **Subscriber** or retiree is secondary and the other **Plan** is primary.
  2. **Dependent Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one **Plan** is:
    - a. The **Primary Plan** is the **Plan** of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that 1 party has the responsibility to provide health care coverage.

If both parents have the same birthday, the **Plan** that covered either of the parents longer is primary.
    - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to **Claim Determination Periods** or **Plan** years commencing after the **Plan** is given notice of the court decree.
    - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The **Plan** of the **Custodial Parent**;
      - The **Plan** of the spouse of the **Custodial Parent**;
      - The **Plan** of the non-custodial parent; and then
      - The **Plan** of the spouse of the non-custodial parent.
  3. **Active or Inactive Employee.** The **Plan** that covers a person as an employee, who is neither laid off nor retired, is the **Primary Plan**. The same holds true if a person is a dependent of a person covered as a retiree and an employee. If the other **Plan** does not have this rule, and if, as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under this section.
  4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **Plan**, the **Plan** covering the person as an employee, **Subscriber** or retiree (or as that person's dependent) is primary, and the



continuation coverage is secondary. If the other **Plan** does not have this rule, and if, as a result, the **Plans** do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** The **Plan** that covered the person as an employee, **Member** or **Subscriber** longer is primary.
6. **If the preceding rules do not determine the Primary Plan,** the **Allowable Expenses** shall be shared equally between the **Plan's** meeting the definition of **Plan** under this section. In addition, this **Plan** will not pay more than it would have paid had it been primary.

#### **Effect on Benefits of this Certificate.**

When this **Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a **Claim Determination Period** are not more than 100% of total **Allowable Expenses**. The difference between the benefit payments that this **Plan** would have paid had it been the **Primary Plan** and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the **Member** and used by this **Plan** to pay any **Allowable Expenses**, not otherwise paid during the claim determination period. As each claim is submitted, this **Plan** will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the **Member**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claim Determination Period**.

If a **Member** is enrolled in 2 or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 **Closed Panel Plan**, **COB** shall not apply between that **Plan** and other **Closed Panel Plans**.

#### **Effect of Medicare.**

The following provisions explain how the benefits under this **Certificate** interact with benefits available under **Medicare**.

A **Member** is eligible for **Medicare** if **Member**:

1. Is covered under **Medicare** by reason of age, disability, or End Stage Renal Disease;
2. Is not covered under **Medicare** because of:
3. Having refused **Medicare**;
4. Having dropped **Medicare**; or
5. Having failed to make proper request for **Medicare**.

If a **Member** is eligible for **Medicare**, coverage under this **Certificate** will be determined as follows:

If a **Member's** coverage under this **Certificate** is based on current employment with the **Contract Holder**, coverage under this **Certificate** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

1. solely due to age if this **Plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);

2. due to diagnosis of End Stage Renal Disease, but only during the first 30 months of such eligibility for **Medicare** benefits. But this does not apply if at the start of such eligibility the **Member** was already eligible for **Medicare** benefits and this **Plan's** benefits were payable on a **Secondary Plan** basis;
3. solely due to any disability other than End Stage Renal Disease; but only if this **Plan** meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

Otherwise, coverage under this **Certificate** will cover the benefits as the **Secondary Plan**. Coverage under this **Certificate** will pay the difference between the benefits of this **Plan** and the benefits that **Medicare** pays, up to 100% of **Plan Expenses**.

Charges used to satisfy a **Member's** Part B deductible under **Medicare** will be applied under this **Plan** in the order received by **HMO**. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating "other plan" benefits with those under this **Plan** will be applied after this **Plan's** benefits have been figured under the above rules.

Those charges for non-emergency care or treatment furnished by a **Member's Physician** under a Private Contract are excluded. A Private Contract is a contract between a **Medicare** beneficiary and a **Physician** who has decided not to provide services through **Medicare**.

This exclusion applies to services an "opt out" **Physician** has agreed to perform under a Private Contract signed by the **Member**. **Physicians** who have decided not to provide services through **Medicare** must file an "opt out" affidavit with all carriers who have jurisdiction over claims the **Physician** would otherwise file with **Medicare** and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a **Medicare** beneficiary.

#### **Multiple Coverage Under this Plan.**

If a **Member** is covered under this **Plan** both as a **Subscriber** and a **Covered Dependent** or as a **Covered Dependent** of 2 **Subscribers**, the following will also apply:

- The **Members** coverage in each capacity under this **Plan** will be set up as a separate "**Plan**".
- The order in which various **Plans** will pay benefits will apply to the "**Plans**" set up above and to all other **Plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **Plan**.

**Right to Receive and Release Needed Information.**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits under this **Plan** and other **Plans**. **HMO** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

**Facility of Payment.**

Any payment made under another **Plan** may include an amount which should have been paid under coverage under this **Certificate**. If so, **HMO** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this **Certificate**. **HMO** will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

**Right of Recovery.**

If the amount of the payments made by **HMO** is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the **Member**. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## **SUBROGATION AND RIGHT OF RECOVERY**

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which another party is or may be responsible, then **HMO** retains the right to repayment of the cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which another party is or may be responsible. **HMO's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from the following sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a **Member** for injuries resulting from an accident or alleged negligence.

The **Member** specifically acknowledges **HMO's** right of subrogation. When **HMO** provides health care benefits for injuries or illnesses for which another party is or may be responsible, **HMO** shall be subrogated to the **Member's** rights of recovery against any party to the extent of the cost of all benefits provided by **HMO**, to the fullest extent permitted by law. **HMO** may proceed against any party with or without the **Member's** consent.

The **Member** also specifically acknowledges **HMO's** right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when **HMO** has provided health care benefits for injuries or illness for which another party is or may be responsible and the **Member** and/or the **Member's** representative has recovered any amounts from another party or any party making payments on the party's behalf. By providing any benefit under this **Certificate**, **HMO** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by **HMO**. **HMO's** right of reimbursement is cumulative with and not exclusive of **HMO's** subrogation right and **HMO** may choose to exercise either or both rights of recovery.

The **Member** and the **Member's** representatives further agree to:

- A. Notify **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of another party; and
- B. Cooperate with **HMO** and do whatever is necessary to secure **HMO's** rights of subrogation and/or reimbursement under this **Certificate**; and
- C. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with injuries or illness provided by **HMO** for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **HMO** in writing; and
- D. Do nothing to prejudice **HMO's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by **HMO**.

**HMO** may recover the full cost of all benefits provided by **HMO** under this **Certificate** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **HMO's** recovery without the prior express written consent of **HMO**.

### **RESPONSIBILITY OF MEMBERS**

- A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.
- B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Subscriber's Covered Dependents**, unless a different notification process is agreed to between **HMO** and **Contract Holder**.
- C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.
- D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions in this **Certificate**.
- E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

## GENERAL PROVISIONS

- A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**, subject to coverage available as specified in the Continuation and Conversion section of this **Certificate**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the **Complaint** procedure set forth in the Complaint Procedure section of this **Certificate**.

- B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:
1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;
  2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
  3. permit copying of the **Member's** records by **HMO**.
- C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the **Complaint** procedure set forth in the Complaint Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.
- D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.
- E. **Legal Action.** No claim in law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **Group Agreement**.

F. **Independent Contractor Relationship.**

1. **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency.
2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.
3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.
4. **HMO** cannot guarantee the continued participation of any **Provider** with **HMO**. In the event a **Participating Provider's** contract with **HMO** terminates or expires, **HMO** shall notify **Members** receiving care from that **Provider** at least 30 days before the effective date of the termination or expiration. Such notification will inform **Members** of the ability to continue to see that **Participating Provider**, subject to the requirements detailed in the section of this **Certificate** entitled "Availability of Coverage in the Event of a Provider Termination."
5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO** or otherwise provided in this **Certificate**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** If, due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law.

1. **Nonpublic Personal Health Information** may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **Certificate**, or other activities as permitted by applicable law.
2. For other purposes, **Nonpublic Personal Health Information** may be disclosed only with the written or electronic consent of the **Member**, or a person legally empowered to grant the authorization on the **Member's** behalf. Such authorization shall comply with applicable law.
3. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services telephone number listed on the **Member's** identification card.

I. **Limitation on Services.** Except in cases of **Medical Emergency** or **Urgent Care**, or as otherwise provided in this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any non-participating **Provider** or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

- J. **Incontestability.** All statements made by **Subscriber** on the enrollment application are considered representations and not warranties. The statements are considered to be truthful and are made to the best of the **Subscriber's** knowledge and belief. A statement may not be used to void, cancel or non-renew a **Member's** coverage or reduce benefits unless a signed copy of the written application is or has been furnished to the **Subscriber** or the **Subscriber's** personal representative.
- K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.
- L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.
- M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.
- N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.
- O. This **Certificate**, including the enrollment application and any attachments, constitutes the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. To be valid, any change, supplement or waiver in the **Certificate**, application or attachments must be approved in writing by an authorized representative of the **HMO** and attached to the affected form. There are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Certificate**. No insurance agent has the authority to change the agreement or waive any of the provisions of the agreement.
- P. If this **Certificate** contains any provision not in conformity with Texas state law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.
- Q. **Payment of Claims to Members.** After receipt of the documentation reasonably necessary to process a claim, **HMO** shall make payment for **Covered Benefits** within 45 days.
- R. Upon verbal or written request by a **Member**, **HMO** will provide the **Member** the name or employee identifier, mailing address, business city and state location, and job title of the employee of **HMO** who is available to the **Member** to respond to communications and questions from the **Member** relating to coverage and benefits provided by **HMO** to the **Member**.



## DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom the claim is made.
- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Body Mass Index.** A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.
- **Certificate.** This Certificate of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Chemical Dependency.** The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.
- **Chemical Dependency Rehabilitation.** Services, procedures and interventions to eliminate the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance, according to individualized treatment plans.
- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the **Coordination of Benefits** section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery.** Any non-Medically Necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Benefits.** Those services and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate** and not otherwise excluded or

limited. **HMO** is obligated to pay for only those **Covered Benefits** that are determined to be **Medically Necessary**.

- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Craniofacial Abnormality.** An abnormal structure or deformity of the cranial and facial bones caused by congenital defects, developmental deformities, trauma, tumors, infections or disease, including a defect of the upper face or midface, a defect of the midface or lower face, or both.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, any health benefit plan under section 5(e) of the Peace Corps Act and short-term limited duration coverage. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.
- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.
- **Delegated Entity.** An entity, other than **HMO**, that arranges for or provides **Medically Necessary Covered Benefits** to a **Member** in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform certain functions on behalf of **HMO**.
- **Delegated Network.** Any **Delegated Entity** that assumes total financial risk for more than 1 of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs. The term does not include a **Delegated Entity** that shares risk for a category of services with **HMO**.
- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while

not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
  7. it is provided or performed in special settings for research purposes.
- **Grace Period.** The 31 day period during each billing cycle in which all **Contract Holder** premiums and fees must be received.
- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
- **Health Information.** Any information or data regarding an individual, other than age or gender, whether oral or recorded in any form or medium, that is created by or derived from **Health Professionals** or the individual and that relates to: (A) the past, present or future physical, mental, or behavioral health or condition of an individual; (B) the provision of health care to an individual; or (C) payment for the provision of health care to an individual.
- **Health Professionals.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **HMO. Aetna Health Inc.,** a Texas corporation licensed by the Texas Department of Insurance as a Health Maintenance Organization.
- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's**

place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
- **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.
- **Hospital.** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
- **Hospitalist.** A **Physician** who serves as the physician-of-record at a **Hospital** for a hospitalized patient of another physician; and returns the care of the patient to that other **Physician** at the end of the patient's hospitalization.
- **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.
- **Limited Provider Network.** A subnetwork of **HMO's Providers** in which contractual relationships exist between **Physicians, Providers**, independent physician associations, or physician groups that limits the **Providers** to which **Members** have access to those **Providers** in the subnetwork.
- **Medical and Scientific Evidence.** The following sources:
  - (a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
  - (b) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR).
  - (c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act (42 U.S.C. 1395x).
  - (d) The following standard reference compendia:
    - i. The American Hospital formulary Service-Drug Information,
    - ii. The American Medical Association Drug Evaluation,
    - iii. The American Dental Association Accepted Dental Therapeutics, and
    - iv. The United States Pharmacopoeia-Drug Information.
  - (e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the:
    - i. Federal Agency for Healthcare Research and Quality,
    - ii. National Institutes of Health,
    - iii. National Cancer Institute,
    - iv. National Academy of Sciences,
    - v. Health Care Financing Administration, and

- vi. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
- (f) Peer-reviewed abstracts accepted for presentation at major medical association meetings.
- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
- **Medical Emergency.** The recent onset of a medical condition of severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
  1. placing the patient's health in serious jeopardy;
  2. serious impairment to bodily functions;
  3. serious dysfunction of any bodily organ or part;
  4. serious disfigurement; or
  5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, loss of consciousness, injuries involving treatment to the mouth and teeth, and conditions that have progressed from a non-emergent situation initially to that of an emergent nature over a period of time, of a few days to as long as a week.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** **Hospital or Medical Services** and supplies that under the applicable standard of care are appropriate:
  - (a) to improve or preserve health, life, or function; or
  - (b) to slow the deterioration of health, life, or function; or
  - (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness, or injury.

Determinations by **HMO** of whether care is **Medically Necessary** under this definition shall also include determinations of whether the services and supplies are cost-effective\*, timely, and sufficient in quality, quantity, and frequency, consistent with the applicable standard of care. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO's** medical director or designee of whether health care services are **Medically Necessary Covered Benefits** under this **Certificate**.

\* For purposes of this definition, "cost-effective" means the least expensive **Medically Necessary** treatment selected from two or more treatments that are equally effective, meaning the care can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects, in achieving a desired health outcome for that particular **Member**.

- **Member.** A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic

methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, anxiety disorders, personality disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

- **Mental Health Treatment Facility.** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmity level **Medical Services** or arranges with a **Hospital** for any other **Medical Services** that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.
- **Morbid Obesity.** A **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk co-morbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Nonpublic Personal Health Information. Health Information:** (A) that identifies an individual who is the subject of the information; or (B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.
- **Open Enrollment Period.** A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician.** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider.** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.
- **Qualified Individual.** A **Member** who is:

1. a postmenopausal woman who is not receiving estrogen replacement therapy;
  2. an individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or
  3. an individual who is receiving long-term glucocorticoid therapy or is being monitored to assess the response to or efficacy of an approved osteoporosis drug.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
  - **Referral.** Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
  - **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.
  - **Service Area.** The geographic area, established by **HMO** and approved by the appropriate regulatory authority. The Service Area includes the following counties in Texas:
    - Aransas, Atascosa, Austin
    - Bastrop, Bee, Bexar, Brazoria, Caldwell, Chambers, Collin, Colorado, Comal, Cooke, Dallas, Delta, Denton, Duval
    - El Paso, Ellis, Erath
    - Fannin, Fort Bend
    - Galveston, Grayson, Grimes, Guadalupe
    - Hardin, Harris, Hays, Henderson, Hill, Hood, Hopkins, Hunt
    - Jefferson, Jim Wells, Johnson
    - Kaufman, Kendall, Kleberg
    - Liberty, Live Oak
    - Matagorda, Medina, Montgomery
    - Navarro, Nueces
    - Orange
    - Palo Pinto, Parker
    - Rains, Rockwall
    - San Jacinto, San Patricio, Somervell
    - Tarrant, Travis
    - Van Zandt
    - Walker, Waller, Wharton, Wilson, Williamson, Wise
  - **Serious Mental Illness.** The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
  - **Skilled Care.** Medical care that requires the skills of technical or professional personnel.
  - **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.

- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.
- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.
- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:
  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.
- **Urgent Care. Covered Benefits** provided in a situation other than a **Medical Emergency** which are typically provided in settings such as a **Physician** or **Provider's** office or **Urgent Care** center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition or his or her health.
- **Urgent Care Services.** Professional health services that are provided to treat an **Urgent Care** situation.



**AETNA HEALTH INC.  
(TEXAS)**

**HOME HEALTH CARE AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Definitions of “**Custodial Care**”, “**Homebound Member**”, “**Skilled Care**” and “**Skilled Nursing Facility**” are hereby deleted and replaced with the following definitions:

- **Custodial Care.** Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:
  1. Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member**.
  2. Care of a stable tracheostomy, including intermittent suctioning.
  3. Care of a stable colostomy/ileostomy.
  4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
  5. Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
  6. Respite care, adult (or child) day care, or convalescent care.
  7. Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
  8. Any services that an individual without medical or paramedical training can perform or be trained to perform.
- **Homebound Member.** A **Member** who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

Examples where a **Member** would not be considered homebound are:

1. A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
  2. A wheelchair bound **Member** who could safely be transported via wheelchair accessible transport.
- **Skilled Nursing.** Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.
  - **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a **Skilled Nursing Facility** under

Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.

The **Home Health Benefits** provision under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

#### **Home Health Benefits.**

The following services are covered for a **Homebound Member** when provided by a **Participating** home health care agency. Pre-authorization must be obtained from the **HMO** by the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide covered health care services. Coverage for **Home Health Services** is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or **Custodial Care** service does not cause the service to become covered. If the **Member** is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for **Home Health Services** will only be provided during times when there is a family member or caregiver present in the home to meet the **Member's** non-skilled needs.

**Skilled Nursing** services that require the medical training of and are provided by a licensed nursing professional are a covered benefit.

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing**.

Medical social services are covered only when they are provided in conjunction with **Skilled Nursing** services and must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met.

The Private Duty Nursing exclusion under the Exclusions and Limitations section of the **Certificate** is hereby deleted and replaced with the following:

- Private Duty Nursing *(See the Home Health Benefits section regarding coverage of nursing services).*

The Exclusions and Limitations section of the **Certificate** is hereby amended to include the following:

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

**AETNA HEALTH INC.  
(TEXAS)**

**WEIGHT CONTROL SERVICES EXCLUSION AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The following exclusions are hereby deleted from the Exclusions and Limitations section of the **Certificate**:

- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.
- Weight reduction programs, or dietary supplements.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following exclusion(s):

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.

**AETNA HEALTH INC.  
(TEXAS)**

**HIPAA SPECIAL ENROLLMENT/ PORTABILITY AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is amended as follows:

The **Special Enrollment Period** provision under the Eligibility and Enrollment section is deleted and replaced with the following:

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption, as described below.

**Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:**

An eligible individual or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c and d are met:

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;
- b. the eligible individual or eligible dependent previously declined coverage in writing under **HMO**;
- c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 of the following reasons:
  - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
  - ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of **HMO** coverage due to **Member** action- movement outside of the **HMO's** service area; and also the termination of health coverage including Non-**HMO**, due to plan termination.
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent
- termination of benefit package

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **Certificate**; and

- d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

**Special Enrollment Period When a New Eligible Dependent is Acquired:**

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, including a child for whom the **Subscriber** is a party in a suit in which the adoption of the child by the **Subscriber** is sought, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption, including the date on which the suit to which the **Subscriber** is a party for the adoption of the child originated.

The eligible individual or the eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

The Definition of “**Creditable Coverage**” is deleted and replaced with the following definition:

- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children’s Health Insurance Program (S-Chip). **Creditable Coverage** does not include coverage only for accident; Workers’ Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

**AETNA HEALTH INC.  
(TEXAS)**

**CERTIFICATE OF COVERAGE AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **HMO Certificate** is amended as follows:

The **Definitions** section of the **Certificate** is hereby amended to add the following:

**Residential Treatment Facility – (Mental Disorders)**

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- It is a facility to which the member is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

**Residential Treatment Facility – (Substance Abuse)**

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- It is a facility to which the member is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.

- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or substance abuse professionals 24 hours per day/7 days a week.



**AETNA HEALTH INC.  
(TEXAS)**

**SUBROGATION AND WORKERS COMPENSATION AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The **Subrogation and Right of Recovery** provision in the **Certificate** is hereby deleted and replaced with the following:

**SUBROGATION AND RIGHT OF REIMBURSEMENT**

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be responsible for injuries or illness to a **Member**. Such injuries or illness are referred to as "Third Party injuries." "Responsible Party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.

If this Plan provides benefits under this **Certificate** to a **Member** for expenses incurred due to Third Party injuries, then **HMO** retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the **Member** that are associated with the Third Party injuries. **HMO's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries.

By accepting benefits under this Plan, the **Member** specifically acknowledges **HMO's** right of subrogation. When this Plan provides health care benefits for expenses incurred due to Third Party injuries, **HMO** shall be subrogated to the **Member's** rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. **HMO** may proceed against any party with or without the **Member's** consent.

By accepting benefits under this Plan, the **Member** also specifically acknowledges **HMO's** right of reimbursement. This right of reimbursement attaches when this Plan has provided health care benefits for expenses incurred due to Third Party injuries and the **Member** or the **Member's** representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries. By providing any benefit under **Certificate**, **HMO** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by this Plan. **HMO's** right of reimbursement is cumulative with and not exclusive of **HMO's** subrogation right and **HMO** may choose to exercise either or both rights of recovery. By accepting benefits under this Plan, the **Member** and the **Member's** representatives further agree to:

- A. Notify **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the **Member**;
- B. Cooperate with **HMO**, provide **HMO** with requested information, and do whatever is necessary to secure **HMO's** rights of subrogation and reimbursement under this **Certificate**;
- C. Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- D. Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement, and regardless of whether such payment will result in a recovery to the **Member** which is insufficient to make the **Member** whole or to compensate the **Member** in part or in whole for the damages sustained), unless otherwise agreed to by **HMO** in writing; and
- E. Do nothing to prejudice **HMO's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan.
- F. Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party injuries.

**HMO** may recover the full cost of all benefits provided by this Plan under this **Certificate** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **HMO's** recovery, and **HMO** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the **Member** to pursue the **Member's** claim or lawsuit against any Responsible Party without the prior express written consent of **HMO**. In the event the **Member** or the **Member's** representative fails to cooperate with **HMO**, the **Member** shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by **HMO** in obtaining repayment.

#### **RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION**

If benefits are provided by **HMO** for illness or injuries to a **Member** and **HMO** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **HMO** has the right to recover as described under the Subrogation and Right of Recovery provision. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims. **HMO** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

- a.) The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;
- b.) No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Members' employment;

- c.) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier; or
- d.) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree to notify **HMO** of any Workers' Compensation claim made, and to reimburse **HMO** as described above.

**AETNA HEALTH INC.  
(TEXAS)**

**OFFICE OF THE OMBUDSMAN AMENDMENT**

**Contract Holder Group Agreement Certificate of Coverage** Effective Date: October 1, 2011

The Aetna Health Inc. Certificates of Coverage and all related documents (the “Plan Documents”) are hereby amended as follows:

All references to the “Office of the Ombudsman.” in the foregoing documents are hereby deleted.

This Office of the Ombudsman Amendment does not alter or affect any other term, provision or condition of the Plan Documents.

This Amendment shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.

**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

**Aetna Health Inc.**, (“**HMO**”) and **Contract Holder** agree to provide to the following provisions:

1. The following is added to the “Termination of Coverage” section of the **Certificate of Coverage**:

**D. End of Coverage Date**

Unless otherwise specified below, the **Member’s** end of coverage date will be the end of the month in which the **Member** is no longer eligible under the plan.

For the purposes of this section, “month” means the period from a date in a calendar month to the corresponding date in the succeeding calendar month. If the succeeding calendar month does not have a corresponding date, the period ends on the last day of the succeeding calendar month.

Examples:

- For calendar months with succeeding corresponding dates: May 5<sup>th</sup> to June 5<sup>th</sup> would equal one “month”.
- For calendar months without succeeding corresponding dates: January 31<sup>st</sup> to February 28<sup>th</sup> would equal one “month”.

The monthly premium required by **HMO** for each **Member’s** coverage will be the applicable rate in effect on the date the coverage ends. The **Contract Holder** will be billed for the amount of premium due for coverage to the end of the month in which the **Member** is no longer eligible under the plan.

2. The following language is hereby deleted from the “Termination of Coverage” section:

**HMO** shall have no liability or responsibility under this **Certificate** for services provided on or after the date of termination of coverage.

## **PROCEDIMIENTO DE QUEJA**

En los casos en que los **miembros** no estén conformes con los servicios de **HMO**, los siguientes procedimientos registrarán las **quejas** y las apelaciones de **quejas** presentadas por los **miembros** o en su nombre.

### **A. Definiciones**

1. Una “consulta” es el pedido que formula un **miembro** para recibir servicios administrativos, obtener información o expresar una opinión, que incluye, entre otros, reclamos sobre el alcance de la cobertura de servicios de salud, negaciones, cancelaciones, terminaciones o renovaciones y sobre la calidad de los servicios brindados. También se puede tratar de un malentendido o de un problema de información errónea, que se resuelven de inmediato aclarando el malentendido o proporcionando la información adecuada para satisfacción del **miembro**.
2. Una “**determinación adversa**” es una disposición que establece que un servicio o suministro no es **médicamente necesario** o adecuado.
3. Una “**queja**” es la expresión oral o escrita de insatisfacción de un **miembro** en forma escrita u oral relativa a algún aspecto de la operación de **HMO**, que puede incluir, por ejemplo:
  - a. la insatisfacción con la administración del plan;
  - b. procedimientos relacionados con la revisión o la apelación de una determinación adversa;
  - c. la negación, la reducción o la terminación de un servicio por razones que no se relacionan con la **necesidad médica** o el carácter apropiado de tal servicio;
  - d. la forma en que se brinda un servicio; o
  - e. decisiones de bajas.

La **queja** no incluye el descontento o el desacuerdo de un **proveedor** o **miembro** en relación con una **determinación adversa**.

### **B. Revisión de quejas**

1. **HMO** enviará al **miembro** el acuse de recibo de la **queja** dentro de los 5 días hábiles de haberla recibido. El acuse de recibo incluirá:
  - a. la fecha de recepción de la **queja**;
  - b. una descripción de los procedimientos y los plazos de **queja** que aplica **HMO**;
  - c. un formulario de **queja** de una página, que establezca claramente que dicho formulario debe enviarse a **HMO** para la resolución inmediata de la **queja**, si esta se presenta en forma oral;
  - d. la solicitud al **miembro** de que brinde información adicional, incluida toda documentación necesaria, para ayudar a **HMO** a manejar y resolver la **queja**; y
  - e. un aviso que informe al **miembro** sobre su derecho a recibir asistencia de un representante de **HMO** ajeno al problema para comprender el proceso de **queja**.

**HMO** acusará recibo, investigará y resolverá las **quejas** dentro de los 30 días calendarios a partir de la fecha de recepción de la **queja** escrita o del formulario de **queja** de una página.

2. El panel de **quejas** a cargo de la revisión estará compuesto por uno o más empleados de **HMO**. No lo integrará ninguna persona cuya decisión sea objeto de la apelación ni ninguna persona que haya tomado la decisión inicial motivo del reclamo o que haya tenido algo que ver con la **queja**.
3. **HMO** enviará al **miembro** una notificación escrita acerca del resultado de la revisión por parte del panel de **quejas**. La notificación incluirá:
  - a. una descripción del modo en que el panel entendió la **queja** del **miembro** como se presentó ante el panel de **quejas** (por ejemplo, el monto en dólares del tema en disputa, los hechos médicos en cuestión, etc.);
  - b. la decisión del panel en términos claros, incluidos los fundamentos del contrato, según corresponda, con el grado de detalle suficiente para que el **miembro** pueda responder a la postura de **HMO** (por ejemplo, los servicios no eran de emergencia como se indicó en el informe médico, los servicios no estaban cubiertos por el **Certificado**);
  - c. mención de las pruebas o los documentos utilizados para fundar la decisión, incluida la especialidad de los **proveedores** que hayan sido consultados (por ejemplo, referencia al **Certificado**, a registros médicos, etc.);
  - d. el anuncio de que la decisión del panel de **quejas** será definitiva y obligatoria salvo que el **miembro** apele ante **HMO** dentro de los sesenta (60) días a partir de la notificación acerca de la decisión del panel de **quejas**; y
  - e. una descripción completa del proceso de apelación de **quejas** y los plazos para la decisión definitiva sobre la apelación.
4. Si el plan de salud del **afiliado** se rige por la Ley de Seguridad de Ingresos de Jubilación de Empleados (ERISA), el **miembro** tiene derecho a entablar una acción civil conforme a la Sección 502(a) de ERISA.

### C. **Apelaciones de quejas**

1. Al recibir de parte de un **miembro** una apelación por escrito de una **queja**, **HMO** debe enviarle una carta de acuse de recibo dentro de los cinco días hábiles. Esta carta debe incluir los procedimientos que rigen las apelaciones presentadas ante el panel de apelaciones, con indicación de la fecha y el lugar en que debe comparecer el **miembro**. El proceso de apelación le brinda al **miembro** la posibilidad de acudir en persona ante el panel de apelación, hacerlo por teléfono o bien apelar por escrito. El **miembro** recibirá una notificación acerca de su derecho a recibir asistencia de un representante de **HMO** ajeno al problema para comprender el proceso de apelación.

Al menos 5 días hábiles antes de presentarse ante el panel de apelación, el **miembro** recibirá una copia de la documentación que presentará el personal de **HMO**, la especialidad de los **médicos** o **proveedores** a quienes se haya consultado durante la revisión, y el nombre y la afiliación de todos los representantes de **HMO** que integrarán el panel de apelación. El **miembro** puede expresar su opinión respecto de esta información para que el panel la tenga en cuenta en las deliberaciones de **HMO**.

2. El panel estará compuesto por igual cantidad de **miembros** de **HMO** que no sean empleados; personal de **HMO** que no haya tenido que ver con la decisión objeto de disputa; y **médicos** o **proveedores** con experiencia en el área de atención en cuestión y que no estén relacionados con los **médicos** o **proveedores** que hayan tomado la decisión que motivó la apelación del **miembro**. Si es la atención de especialistas lo que está en disputa, el panel de apelación incluirá una persona que sea **especialista** en el área con la que está vinculada la apelación.
3. El panel de apelación llevará a cabo audiencias en el condado donde reside el **miembro** o donde normalmente recibe los servicios de atención de salud de **HMO**. Se podrá elegir otro lugar si el **miembro** y **HMO** así lo convienen.
4. El **miembro** tendrá derecho a asistir a la audiencia de apelación en persona o por teléfono, a hacer preguntas al representante de **HMO** designado para comparecer en la audiencia o a cualquier otro testigo, incluidos los responsables de haber tomado la determinación que dio lugar a la apelación, y a exponer sus argumentos. El **miembro** también tendrá derecho a la asistencia o la representación por parte de una persona de su elección y a presentar material escrito para respaldar su **queja**. Además, podrá estar acompañado, pero el acompañante no podrá participar en la audiencia salvo que el **miembro** sea menor o discapacitado, en cuyo caso el acompañante podrá representarlo. El acompañante puede ser un amigo, un abogado o un familiar del **miembro**. Éste puede llevar a un **médico** u otro experto para que testifique en su nombre. **HMO** también tendrá derecho a presentar testigos. El panel de apelación tendrá derecho a hacer preguntas al representante de **HMO**, al **miembro** y a cualquier otro testigo.
5. La audiencia de apelación tendrá un carácter informal. El panel de apelación no podrá aplicar reglas formales de evidencia al revisar la documentación o al aceptar declaraciones testimoniales en la audiencia.
6. **HMO** redactará un acta de la audiencia de apelación.
7. Antes de cerrar el acta, el presidente del panel de apelación preguntará al **miembro** y al representante de **HMO** (o a su abogado) si desean exponer alguna otra evidencia o argumento ante el panel de apelación. Una vez que se hayan expuesto en su totalidad la evidencia y los argumentos, se cerrará el acta de la audiencia de apelación. Las deliberaciones del panel de apelación revestirán carácter confidencial y no podrán transcribirse.
8. El panel emitirá una decisión por escrito dentro de los 30 días calendario a contar desde que se presentó la apelación. La decisión incluirá:
  - a. la fecha de recepción de la solicitud de apelación, haya sido oral o escrita;
  - b. una declaración de cuáles son, según el panel de apelación, la naturaleza de la **queja** y los hechos sustanciales relacionados con ella;
  - c. la decisión y los fundamentos del panel de apelación, que incluyen el enunciado de la determinación específica, los fundamentos clínicos y los criterios contractuales utilizados para llegar a la decisión definitiva;
  - d. un resumen de la evidencia, incluidos los documentos necesarios para respaldar la decisión;
  - e. si corresponde, la mención del derecho del **miembro** a solicitar una **revisión externa**; y



- f. la mención del derecho del **miembro** a apelar ante el Departamento de Seguros, con indicación del siguiente número telefónico gratuito y de la dirección completa de dicha entidad:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714 - 9104  
1-800-252-3439

9. Cuando lo solicite y sin costo alguno, el **miembro** o la persona que éste designe tendrá acceso razonable a todos los documentos, registros u otra información pertinente al reclamo o a la apelación que se relacionen con una determinación de beneficios, así como a las copias de dichos documentos, registros o información, incluidos:
- aquellos en los que se basa la determinación de beneficios;
  - aquellos presentados, considerados o generados en el transcurso de la determinación de beneficios, ya sea que esta se haya basado o no en ellos;
  - aquellos que demuestren el cumplimiento de los procesos administrativos y las garantías aplicadas en la determinación de beneficios; y
  - aquellos que constituyen una declaración de política o asesoramiento en cuanto al **Certificado** en relación con el beneficio o la opción de tratamiento para el diagnóstico del **miembro** que hayan sido rechazados, ya sea que la determinación de beneficios se haya basado o no en tal asesoramiento o declaración.

#### D. **Apelación de determinaciones adversas**

1. El descontento o desacuerdo expresado en forma oral o escrita con respecto a una **determinación adversa** por parte de un **miembro**, una persona expresamente autorizada a actuar en su nombre o un **proveedor** designado del **miembro** se considerará una apelación de **determinación adversa**. **HMO** entregará a la parte apelante una carta que indique la fecha de recepción de la apelación dentro de los 5 días hábiles de haberla recibido. Esta carta debe describir el proceso de apelación de **determinaciones adversas** e informar al **miembro** sobre su derecho a recibir asistencia de un representante de **HMO** ajeno al problema para comprender el proceso de apelación. En el caso de apelaciones orales, la carta de acuse de recibo incluirá un formulario de apelación de una página que deberá completar la parte apelante.
2. En situaciones en que el **miembro** padece una condición que conlleva peligro de muerte, tiene derecho a apelar de inmediato (como se describe a continuación) ante una organización de revisión independiente (IRO) y no está obligado a completar el proceso de apelación de **determinaciones adversas** de **HMO**. Una condición con peligro de muerte es una enfermedad u otra condición médica en la que existe probabilidad de muerte salvo que se interrumpa el progreso de la enfermedad o condición.
3. Al recibir una apelación de **determinación adversa**, **HMO** solicitará al **miembro** o a los **proveedores** involucrados en el caso toda información nueva que no se haya tenido en cuenta antes de la **determinación adversa** inicial. El caso se remitirá para su revisión a un **proveedor** que no lo haya revisado ni esté relacionado con él.
4. **HMO** tomará una decisión sobre cada apelación de **determinación adversa** y notificará a la parte apelante sobre el resultado dentro de los 30 días de haber recibido la apelación. Las apelaciones de **determinaciones adversas** relacionadas con emergencias existentes o rechazos de hospitalización continua contemplarán la urgencia dental o médica del caso,

pero no podrá excederse el plazo de un día hábil tras recibir la apelación (lo cual incluye toda la información necesaria para el procedimiento de apelación).

5. **HMO** notificará a la parte apelante sobre el resultado de la apelación de la **determinación adversa** por escrito y especificará la razón y los fundamentos clínicos de la decisión y la especialidad de los revisores. La primera notificación del resultado de las apelaciones de **determinaciones adversas** relacionadas con emergencias existentes o rechazos de hospitalización continua puede cursarse en forma oral si dentro de los 3 días siguientes se realiza por escrito.
6. Si una **determinación adversa** se confirma tras la apelación, el **miembro** podrá apelar ante una organización de revisión independiente, como se explica a continuación.

E. **Apelación ante una organización de revisión independiente (IRO)**

**HMO** participa en el proceso de organizaciones de revisión independientes (IRO) de Texas. Un **miembro**, una persona expresamente autorizada a actuar en su nombre o un **proveedor** (con el consentimiento escrito del **miembro**) cuya apelación de **determinación adversa** se rechaza tiene derecho a solicitar la revisión de la determinación por parte de una IRO conforme a las leyes estatales. Dentro de los tres días hábiles a partir de la fecha en que reciba una solicitud de revisión, **HMO** entregará a la IRO:

1. los registros médicos del **miembro** que resulten pertinentes para la revisión;
2. los documentos utilizados por **HMO** para tomar la determinación;
3. la notificación escrita de la decisión de la audiencia de apelación enviada al **miembro**;
4. toda documentación e información escrita presentada a **HMO** para respaldar la apelación;  
y
5. una lista de los **proveedores** que hayan atendido al **miembro** y que puedan tener registros médicos pertinentes para la apelación.

La determinación de la IRO en cuanto a la **necesidad médica** o al carácter apropiado de los elementos y servicios de atención de salud para un **miembro** es obligatoria para **HMO** y **HMO** pagará la revisión independiente.

F. **Agotamiento del proceso**

Los procedimientos y procesos precedentes son obligatorios y deben agotarse antes de iniciar un litigio, arbitraje o procedimiento administrativo sobre el supuesto incumplimiento del **Contrato de grupo** o **Certificado** por parte de **HMO** o sobre cualquier asunto dentro del alcance del proceso de **queja** y **determinación adversa**. Los procedimientos y procesos precedentes no reemplazan ningún derecho legal de los **miembros** a iniciar un litigio, arbitraje o procedimiento administrativo.

G. **Conservación de registros**

**HMO** conservará los registros de todas las **quejas** durante un período no menor a tres años a partir de la fecha de recepción de la **queja**. Los registros incluirán todas las **quejas** y los procedimientos de **queja** así como las medidas tomadas al respecto. Los **miembros** tienen derecho a recibir una copia del registro de la **queja** y de los procedimientos de **queja** correspondientes.

H. **Honorarios y gastos**

Excepto los gastos vinculados con la revisión independiente de una IRO, ninguna disposición del presente podrá interpretarse como una obligación de **HMO** de pagar los honorarios de abogados u otros honorarios o gastos en que incurra un **miembro** al presentar una **queja** o apelación.

- I. **HMO** no podrá negarse a renovar ni podrá cancelar la cobertura del **titular del contrato** o de un **miembro** ni podrá tomar ninguna otra medida de represalia porque estos hayan presentado una **queja** o apelado una **determinación adversa**. **HMO** no podrá negarse a renovar ni podrá terminar un contrato con un **proveedor participante** o con un **médico participante** como represalia por haber presentado una **queja** o apelado una **determinación adversa** en nombre de un **miembro**.

**AETNA HEALTH INC.  
(TEXAS)**

**GENERAL PROVISIONS AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Assignment of Benefits provision now appearing in Item D. of the **Certificate** Section entitled “General Provisions” is hereby deleted and replaced with the following.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member**. To the extent allowed by law, **HMO** may choose not to accept assignment to a provider including but not limited to an assignment of:

- The benefits due under the **Group Agreement**;
- The right to receive payments due under the **Group Agreement**; or
- Any claim the Member makes for damage resulting from a breach, or alleged breach, of the term of the **Group Agreement**.

**HMO** will notify the **Member** in writing, at the time it receives a claim, when an assignment of benefits to a health care **Provider** will not be accepted.

**AETNA HEALTH INC.  
TEXAS**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement Effective Date:** October 1, 2011

**The Aetna Health Inc. Certificate of Coverage is hereby amended as follows:**

- The following is added to **Outpatient Rehabilitation Benefits** for Acquired Brain Injury coverage:

Coverage will also include outpatient day treatment services, or other post-acute care treatment services.

Reasonable expenses for periodic reevaluation of the care provided under this section will be considered **Medically Necessary** for a **Member** who:

- (1) has incurred an acquired brain injury;
- (2) has been unresponsive to treatment; and
- (3) becomes responsive to treatment at a later date.

A determination of whether expenses, as described above are “reasonable” may include consideration of factors including:

- Cost;
- The time that has expired since the previous evaluation;
- Any difference in the expertise of the physician or practitioner performing the evaluation;
- Changes in technology; and
- Advances in medicine.

- The following is added to the “**Medically Necessary Covered Benefits**” section:

**Treatment of Autism Spectrum Disorder**

Covered dependent children older than two years of age and younger than six years of age who have been diagnosed with **Autism Spectrum Disorder** are covered for all generally recognized services prescribed in a treatment plan for **Autism Spectrum Disorder** by the child’s **Primary Care Physician** in the treatment plan recommended by that **Physician**. The **Provider** of this treatment must:

- be licensed, certified, or registered by an appropriate agency of Texas;
- have professional credentials that are recognized and accepted by an appropriate agency of the United States; or
- be certified as a **Provider** under the TRICARE military health system.

“Generally recognized services” may include:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or

- medications or nutritional supplements used to address symptoms of **Autism Spectrum Disorder**.
- The following are added to the “**Definitions**” section:

#### **Autism Spectrum Disorder**

A **Neurobiological Disorder** that includes autism, Asperger's syndrome, or a pervasive developmental disorder, not otherwise specified.

#### **Neurobiological Disorder**

An illness of the nervous system caused by genetic, metabolic, or other biological factors.

- The definition of “**Serious Mental Illness**” is deleted and replaced by the following:

#### **Serious Mental Illnesses**

This means the following **Serious Mental Illnesses** as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders":

- bipolar disorders (hypomanic, manic, depressive, and mixed);
- depression in childhood and adolescence;
- major depressive disorders (single episode or recurrent);
- obsessive-compulsive disorders;
- paranoid and other psychotic disorders;
- schizo-affective disorders (bipolar or depressive); and
- schizophrenia.

**AETNA HEALTH INC.  
(TEXAS)**

**HIPAA/CHIPRA SPECIAL ENROLLMENT AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate**, and/or any applicable amendment to the **Certificate** is hereby amended as follows:

The **Special Enrollment Period** provision under the Eligibility and Enrollment section is deleted and replaced with the following:

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during a Special Enrollment Periods. A Special Enrollment Period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, placement for adoption of a child or placement of a child for whom you are a party in a suit in which the adoption of the child is sought.

**Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:**

An eligible individual or an eligible dependent may be enrolled during a Special Enrollment Period, if the following requirements, as applicable, are met:

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;
- b. the eligible individual or eligible dependent previously declined coverage [in writing] under **HMO**;
- c. the eligible individual or eligible dependent becomes eligible for State premium assistance in connection with coverage under **HMO**.
- d. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:
  - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted;
  - ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated; or
  - iii. the other health insurance coverage is Medicaid or an S-Chip plan and the eligible individual or eligible dependent no longer qualifies for such coverage.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;

- termination of **HMO** coverage due to **Member** action- movement outside of the **HMO's** service area; and also the termination of health coverage including Non-**HMO**, due to plan termination.
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent
- termination of benefit package

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **Certificate**.

To be enrolled in **HMO** during a Special Enrollment Period, the eligible individual or eligible dependent must enroll within:

- 31 days, beginning on the date of the eligible individual's or eligible dependent's loss of other group health plan or other health insurance coverage; or
- 60 days, beginning on the date the eligible individual or eligible dependent
  - becomes eligible for premium assistance in connection with coverage under **HMO**, or
  - is no longer qualified for coverage under Medicaid or S-Chip.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

**Special Enrollment Period When a New Eligible Dependent is Acquired:**

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.



**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE  
CONTINUATION COVERAGE FOR DEPENDENT STUDENTS ON MEDICAL LEAVE OF ABSENCE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO Certificate of Coverage** is hereby amended as follows:

The following sub-section "Continuation Coverage for Dependent Students on Medical Leave of Absence" is hereby added to the "Continuation and Conversion" section of the **Certificate**:

**Continuation Coverage for Dependent Students on Medical Leave of Absence**

If a **Member**, who is eligible for coverage and enrolled in **HMO** by reason of his or her status as a student at a postsecondary educational institution, ceases to be eligible due to:

1. a medically necessary leave of absence from school; or
2. a change in his or her status as a student,

resulting from a serious illness or injury, such **Member's** coverage under the **Group Agreement** and this **Certificate** may continue.

Any **Covered Dependent's** coverage provided under this continuation provision will cease upon the first to occur of the following events:

1. the end of the 1 year period following the first day of the dependent child's leave of absence from school, or change in his or her status as a student;
2. the dependent child's coverage would otherwise end under the terms of this plan;
3. the **Contract Holder** discontinues dependent coverage under this plan; or
4. the **Subscriber** fails to make any required contributions toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school immediately before the first day of the leave of absence or the change in his or her status as a student.

In order to continue coverage for a dependent child under this provision, the **Subscriber** must notify the **Contract Holder** as soon as possible after the child's leave of absence begins or a change in student status occurs. **HMO** may require a written certification from the treating **physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or other change in full-time student status) is medically necessary.

If:

1. a dependent child's eligibility under a prior plan is a result of his or her status as a student at a postsecondary educational institution; and
2. such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in student status); and
3. this plan provides coverage for eligible dependents;

coverage under **HMO** will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided above.

All other terms and conditions of the **Group Agreement** and this **Certificate of Coverage** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. Certificate of Coverage is hereby amended as follows:

The Outpatient Rehabilitation Benefits section of Medically Necessary Covered Benefits is hereby deleted and replaced by the following:

- **Outpatient Rehabilitation Benefits.**

A **Member** is covered for rehabilitative services and physical, speech and occupational therapies rendered by a **Participating Provider** that, in the opinion of a **Participating Physician**, are **Medically Necessary**. Services and therapies may not be denied, limited or terminated if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

A **Member** is also covered for the following which result from and are related to an **Acquired Brain Injury**.

1. Cognitive rehabilitation therapy: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
2. Cognitive communication therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
3. Neurocognitive therapy: Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
4. Neurocognitive rehabilitation: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
5. Neurobehavioral testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
6. Neurobehavioral treatment: Interventions that focus on behavior and the variables that control behavior.
7. Neurophysiological testing: An evaluation of the functions of the nervous system.
8. Neurophysiological treatment: Interventions that focus on the functions of the nervous system.
9. Neuropsychological testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
10. Neuropsychological treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
11. Neurofeedback therapy: Services that utilize operant conditioning learning procedure based on

electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

12. Remediation: The process(es) of restoring or improving a specific function.
13. Post-acute transition services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
14. Post-acute care treatment services: Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
15. Community reintegration services: Services that facilitate the continuum of care as an affected individual transitions into the community.
16. Other similar coverage: The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.
17. Outpatient day treatment services: Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
18. Psychophysiological testing: An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
19. Psychophysiological treatment: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Reasonable expenses for periodic reevaluation of the care provided under this section will be considered **Medically Necessary** for a **Member** who:

- (1) has incurred an acquired brain injury;
- (2) has been unresponsive to treatment; and
- (3) becomes responsive to treatment at a later date.

A determination of whether expenses, as described above are “reasonable” may include consideration of factors including:

- Cost;
- The time that has expired since the previous evaluation;
- Any difference in the expertise of the physician or practitioner performing the evaluation;
- Changes in technology; and
- Advances in medicine.

Any exclusion or limitation appearing elsewhere in the **Certificate**, which in and of itself meets the definition of a therapy or describes another service or supply eligible for coverage under the Acquired Brain Injury provision, will not apply for Acquired Brain Injury coverage under the plan.

**Coverage for Acquired Brain Injury is subject to the same copayments and other cost-sharing terms as any other similar injury or illness under the plan.**

The Definitions section is enlarged to include the following:

- **Acquired Brain Injury**

A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**AETNA HEALTH INC.  
(TEXAS)**

**RIDER TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

**The Aetna Health Inc. Certificate of Coverage is hereby enlarged to include the following:**

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN

**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE PRESCRIPTION DRUG RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

**The Aetna Health Inc. Prescription Drug Rider is hereby amended as follows:**

The “**Covered Benefits**” section is enlarged to include the following:

- **Amino Acid-Based Elemental Formulas**

Coverage will be provided for amino acid-based elemental formulas, if the **Member’s physician** has issued a written order stating that an amino acid-based elemental formula is **medically necessary** for the **Member’s** treatment after the **Member** has been diagnosed with any of the following diseases or disorders:

1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2. severe food protein-induced enterocolitis syndrome;
3. eosinophilic disorders, as evidenced by the results of a biopsy; and
4. impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Coverage is provided regardless of the formula delivery method. Coverage includes any **medically necessary** services associated with the administration of the formula.

*Any reference in the Prescription Drug Rider to the exclusion or limitation of the above covered services and supplies, unless expressly outlined in this amendment, shall not apply.*

**AETNA HEALTH INC.  
TEXAS**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement Effective Date:** October 1, 2011

**The Aetna Health Inc. Certificate of Coverage is hereby amended as follows:**

1. The “**Medically Necessary Covered Benefits**” section is enlarged to include the following:

**Treatment of Autism Spectrum Disorder**

All generally recognized services prescribed in a treatment plan for **autism spectrum disorder** by a covered dependent child’s **primary care physician** are covered. Coverage will be provided from the date of diagnosis until the covered dependent child completes nine years of age and will include all of the services and supplies recommended by that **Physician** in the treatment plan. The **Provider** of this treatment must:

- be licensed, certified, or registered by an appropriate agency of Texas;
- have professional credentials that are recognized and accepted by an appropriate agency of the United States; or
- be certified as a **Provider** under the TRICARE military health system.

“Generally recognized services” may include:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of **autism spectrum disorder**.

**Clinical Trials**

The plan includes coverage for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

1. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United States Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

“Routine patient care costs” means the costs of any **medically necessary** covered benefit that would have been covered under the plan even if the **Member** had not been participating in a clinical trial.



Routine patient care costs do not include:

- the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- the cost of a service or supply that is not a **medically necessary** covered benefit, regardless of whether the service or supply is required in connection with participation in a clinical trial;
- the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- a cost associated with managing a clinical trial; or
- the cost of a service or supply that is specifically excluded from coverage under a the plan.

All plan deductibles, coinsurance and copayments that would typically apply under the plan for routine patient care costs will apply when this care is received during the course of a clinical trial.

Limitations:

1. The plan is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the plan at either the **Negotiated Charge** or the **Recognized Charge**, as appropriate for the particular provider, as payment in full for the routine patient care provided in connection with the clinical trial.
2. The plan will not provide coverage for services and supplies that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.
3. The plan will not provide coverage for routine patient care provided Out-of-Network unless Out-of-Network coverage for such care is otherwise provided under the plan.
4. The plan will not provide coverage for services and supplies provided outside of Texas.

#### **Early Detection of Cardiovascular Disease**

The plan includes coverage for certain tests for the early detection of cardiovascular disease for any **Member** who is:

1. male and older than 45 years of age and younger than 76 years of age; or
2. female and older than 55 years of age and younger than 76 years of age;

and who is:

- Diabetic; or
- Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

If performed by a laboratory that is certified by a national organization recognized by Texas for the purposes of this section, coverage will be provided for up to \$200 every five years for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function:

- computed tomography (CT) scanning measuring coronary artery calcification; or
- ultrasonography measuring carotid intima-media thickness and plaque.

#### **Orthotic Devices**

The plan includes coverage for orthotic devices, including custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the **Member**.

Coverage is limited to the most appropriate model orthotic device that adequately meets the medical needs of the covered person as determined by the covered person's treating **physician**, podiatrist or orthotist, and the **Member** as applicable.

2. The "Prosthetic Appliances Benefits" provision of "Medically Necessary Covered Benefits" is deleted and replaced by the following:

#### **Prosthetic Appliances Benefits**

Prosthetic devices, including breast prostheses, that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects, are covered under the plan. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the covered person. Covered prosthetic appliances include those items covered by Medicare unless specifically excluded under the plan.

Coverage is limited to the most appropriate model prosthetic device that adequately meets the medical needs of the covered person as determined by the covered person's treating **physician** or prosthetist, and the covered person, as applicable.

3. The following Exclusion is deleted from the "Exclusions and Limitations" section:

Orthotics

4. The following are added to the "**Definitions**" section:

#### **Autism Spectrum Disorder**

A **neurobiological disorder** that includes autism, Asperger's syndrome, or a pervasive developmental disorder, not otherwise specified.

#### **Neurobiological Disorder**

An illness of the nervous system caused by genetic, metabolic, or other biological factors.

5. The definition of “**Serious Mental Illness**” is deleted and replaced by the following:

**Serious Mental Illnesses**

This means the following **serious mental illnesses** as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders":

- bipolar disorders (hypomanic, manic, depressive, and mixed);
- depression in childhood and adolescence;
- major depressive disorders (single episode or recurrent);
- obsessive-compulsive disorders;
- paranoid and other psychotic disorders;
- schizo-affective disorders (bipolar or depressive); and
- schizophrenia.

*Any reference in the **Certificate of Coverage** to the exclusion or limitation of any of the above covered services and supplies, unless expressly outlined in this amendment, shall not apply.*

**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. Certificate of Coverage is hereby modified as shown below.

1. The **Definitions** section is expanded to include the following:

**Freestanding Emergency Medical Care Facility.** A facility, appropriated licensed under the Texas Health and Safety Code, that is structurally separate and distinct from a **Hospital** and that receives an individual and provides **Emergency Service(s)**.

2. In the **Definitions** section the definition of “**Emergency Service**” is deleted and replaced with the following:

**Emergency Service(s).**

This means health care services provided in a **Hospital’s** emergency facility, a **Freestanding Emergency Medical Care Facility** or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that the individual’s condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- place the **Member’s** health in serious jeopardy; or
- result in serious impairment to bodily functions; or
- result in serious dysfunction of a bodily organ or part; or
- result in serious disfigurement; or
- in the case of a pregnant woman, result in serious jeopardy to the health of the fetus.

3. The **Emergency Care Benefits** section is deleted and replaced by the following:

• **Emergency Care Benefits.**

A **Member** is covered for **Emergency Services** provided to the **Member** in a **Hospital** emergency facility, **Freestanding Emergency Medical Care Facility** or comparable emergency facility.

Benefits include:

1. A medical screening examination/evaluation, in accordance with any state or federal law, the purpose of which is to determine whether a **Medical Emergency** exists;
2. The treatment and stabilization of the **Member** for a **Medical Emergency**;
3. Post-stabilization services originating in a **Hospital** emergency facility, **Freestanding Emergency Medical Care Facility** or comparable emergency facility following treatment or stabilization of a **Medical Emergency**, as approved by **HMO**. In addition, the **HMO** reserves the right to approve or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request.

The **Copayment** for an emergency room or **Freestanding Emergency Medical Care Facility** visit as described on the Schedule of Benefits will not apply if the **Member** is admitted as an inpatient at the time of the emergency visit. Instead, the **Member** will be responsible for the applicable inpatient **Copayment**, if any, as shown in the Schedule of Benefits.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**.

In the event that transportation is **Medically Necessary**, and it is provided by a non-participating **Provider**, **HMO** will reimburse the non-participating **Provider** at the usual and customary or agreed upon rate minus any applicable **Copayments**.

**Emergency Medical Care** received at a hospital emergency room, **Freestanding Emergency Medical Care Facility** or comparable emergency facility is subject to the emergency facility copayment shown in the **Schedule of Benefits**.

Medical transportation is covered during a **Medical Emergency**.

A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care situation has terminated. All follow-up and continuing care must be provided or arranged by a **Participating Provider**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

In determining whether services provided to a **Member** will be covered as **Emergency Services**, **HMO** has the right to review the services and the circumstances in which the **Member** received them.

- If the **Member's** condition is a **Medical Emergency**, **HMO** will cover the medical screening examination, evaluation, stabilization and treatment.
- If the **Member's** condition is not a **Medical Emergency**, **HMO** will cover only the medical screening examination and evaluation.
- If the **Member** wishes to appeal a denial of payment for **Emergency Services** based on failure to meet the prudent layperson standard, as that standard is outlined in the "**Emergency Service(s)**" definition shown on page 1, above or for any other reason, the **Member** may appeal under the process described in the "**Complaints and Appeals**" section.

4. The term "emergency room" is replaced in the **Certificate**, wherever it appears with:

"Emergency Room, **Freestanding Emergency Medical Care Facility**, or comparable emergency facility"

**AETNA HEALTH INC.  
(TEXAS)**

**COMPASSIONATE CARE AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

1. The **Hospice Care** definition in the Definitions section of the **Certificate** is deleted and replaced with the following:
  - **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live.

**AETNA HEALTH INC.  
(TEXAS)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **Aetna Health Inc. Certificate of Coverage** is hereby amended as follows.

Section B of the “Continuation and Conversion” section, entitled “Continuation of Coverage – State of Texas” is replaced by the following:

**B. Continuation of Coverage - State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

- a. the death of the **Subscriber**;
- b. the retirement of the **Subscriber**; or
- c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid.

If the group coverage provides continuation rights for **Members** to cover the period between the time the **Member** retires and the time of eligibility for Medicare, the same continuation shall be made available to **Dependents**.

If the **Contract Holder** replaces the group coverage with another plan within one year of the **Dependent's** option to continue coverage, the **Dependent** may obtain coverage identical to the replacement group coverage.

Any period of previous coverage under the group coverage will be used as full or partial satisfaction, as is applicable, for any required coverage probationary period or waiting period.

Evidence of insurability shall not be required for **Dependents** exercising the option to continue coverage.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;
- b. the end of the 3 year period after the date of the divorce or legal separation;

- c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or
- d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. **Group Continuation Privilege.**

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination, shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 60 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder** not later than the 45th day of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**. Subsequent premium contributions must be given to the **Contract Holder** on the premium due date and will be considered to have been paid on time if paid not later than the 30<sup>th</sup> day of such due date.

Continuation of coverage under this section will terminate on the earliest to occur of:

- a. six months after the date the election is made if the **Member** is eligible for COBRA;
- b. nine months after the date the election is made if the **Member** is not eligible for COBRA;
- c. the date on which failure to make timely payments would terminate coverage;
- d. the date on which the group coverage terminates in its entirety;
- e. the date on which the **Member** is or could be covered under **Medicare**;
- f. the date on which the **Member** is covered for similar benefits, other than COBRA, by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program.

3. **Texas Health Insurance Risk Pool**

A **Member** may be eligible for coverage under the Texas Health Insurance Risk Pool. Not later than 30 days prior to the end of the **Member's** coverage under the "Continuation of Coverage - State of Texas" section of this **Certificate**, **HMO** will provide the **Member** with the Texas Health Insurance Risk Pool's address and toll-free telephone number.



**AETNA HEALTH INC.  
(TEXAS)**

**CERTIFICATE OF COVERAGE AND  
SCHEDULE OF BENEFITS  
AMENDMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate** is hereby amended as follows:

- The eligibility rules for **Covered Dependents** in the Eligibility and Enrollment section of the **Certificate** and the Dependent Eligibility section of the Schedule of Benefits have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or chiefly dependent upon the **Subscriber** for support will not apply. All other dependent eligibility rules still apply.

If the **Subscriber** has a child that can now be enrolled, the **Subscriber** may contact Member Services for details.

**Covered Benefits** for a **Covered Dependent** who is not capable of self-support due to mental or physical incapacity will be continued past the maximum age for a child.

- If the **Certificate**, including any amendments or riders, contains a Limitation for Preexisting Conditions, including one that may apply to transplant coverage, then this provision will not apply to **Members** under 19 years of age.
- Any overall plan Calendar Year; **Contract Year**; or Lifetime Maximum Benefits that are dollar maximums in the Schedule of Benefits no longer apply. All references to these overall plan dollar maximums that may appear in the Schedule of Benefits and **Certificate**, including any amendments or Riders, which have been issued to the **Member** are removed.
- The following Preventive Care services are **Covered Benefits**, and will be paid at 100% with no cost-sharing such as **Copayment**, **Deductibles** and dollar maximum benefits:
  - **Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Service Task Force (USPSTF);**
  - Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
  - Routine Well Child Care (including immunizations);
  - Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies); and
  - Routine Gynecological Exams, including routine Pap smears.

**The preventive care services and immunizations listed above may change as the USPSTF, Centers for Disease Control and Prevention, (CDC), and Health Resources and Services Administration, (HRSA) guidelines are modified. For more information you may visit Aetna's website at [www.Aetna.com](http://www.Aetna.com).**

These benefits will be subject to age; family history; and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to the **Member**, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or

- the state laws and regulations that govern the **Group Agreement**.
- Any calendar year; **Contract Year**; or lifetime dollar maximum benefit that applies to an “Essential Service” listed below, no longer applies. Essential Health Benefit categories are subject to change pending the Secretary of Health and Human Services’ definition of Essential Health Benefits.

If the following Essential Services are **Covered Benefits** under the **Member's Certificate**, and such **Covered Benefits** include these dollar maximums, then the maximums are removed from the Schedule of Benefits and **Certificate**, including any amendments or riders, which have been issued to the **Member**:

**Ambulatory Patient Services**, including:

- Primary Care Physician (**PCP**) Office Visits (including E-visits)
- Specialist Physician Office Visits (including E-visits)
- Walk-in Clinic visits

**Emergency Services:**

- Including medical transportation during a Medical Emergency

**Hospitalization:**

- Inpatient
- Outpatient

**Maternity and Newborn Care**

**Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment**

**Prescription Drugs:**

- Outpatient
- Injectable Medications

**Rehabilitative and Habilitative Services and Devices**

**Laboratory Services:**

- Diagnostic X-Ray and Laboratory Testing

**Preventive and Wellness Services and Chronic Disease Management**

**Pediatric Services, Including Oral and Vision Care**

THE ABOVE ESSENTIAL SERVICES MAY NOT BE **COVERED BENEFITS** UNDER THE **MEMBER'S CERTIFICATE**. **MEMBERS** SHOULD REFER TO THEIR **CERTIFICATE** FOR A COMPLETE LIST OF **COVERED BENEFITS** AND EXCLUSIONS AND LIMITATIONS.

Essential Services will continue to be subject to any **Copayments**, **Deductibles**, other types of maximums (e.g., day and visit), **Referral** and pre-authorization rules, and exclusions and limitations that apply to these **Covered Benefits** as indicated in the Schedule of Benefits and **Certificate**, including any amendments or riders.

- Office visits for obstetrical care, including preventive, routine and diagnostic, are now Direct Access Specialist Benefits and are covered without a **Referral** or pre-authorization when rendered by a **Participating Provider**.
- A **Member's** coverage under the **Certificate** may be rescinded in the case of fraud or intentional misrepresentation of material fact. If a **Member's** coverage is rescinded, **HMO** will provide the **Member** with a 30-day advance written notice prior to the date of the rescission.

- The following “Essential Services Maximum Benefit” has been added to your Schedule of Benefits:

<b>Benefit</b>	<b>Maximum</b>
<b>Essential Services Maximum Benefit</b>	Does Not Apply

**AETNA HEALTH INC.  
(TEXAS)**

**ROUTINE EYE EXAMINATION RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO Certificate of Coverage** is hereby amended as follows:

The Covered Benefits section of the **Certificate** is hereby amended to add the following Direct Access Specialist Benefits:

The following services are covered without a **Referral** when rendered by a **Participating Provider**:

- Routine Eye Examinations, including refraction, as follows:
  1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
  2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
  3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
  4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

The following is deleted from the Exclusions and Limitations section of the **Certificate**:

- Routine eye examinations, including refraction.

The Schedule of Benefits is hereby amended to add the following:

<b><u>Benefit</u></b>	<b><u>Copayment</u></b>
<b>Eye Examination by a Specialist (including refraction) as per schedule above</b>	<b>\$0 per visit</b>

**AETNA HEALTH INC.  
(TEXAS)**

**DURABLE MEDICAL EQUIPMENT RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO Certificate of Coverage** is hereby amended as follows:

The Covered Benefits section of the **Certificate** is hereby amended to add the following additional benefits:

- **Durable Medical Equipment Benefits.** **Durable Medical Equipment**, including crutches, will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing; therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, are also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are the **Member's** responsibility.

**Copayment.** The **Member** is responsible for the following **Copayment**: \$0 per item.

The **Member's** annual maximum benefit is Unlimited per **calendar year**.

The following is deleted from the Exclusions and Limitations section of the **Certificate**:

- **Durable Medical Equipment**

Section C of the Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

The conversion privilege does not apply to the **Durable Medical Equipment** Rider.

**AETNA HEALTH INC.  
(TEXAS)**

**PROSTHETIC APPLIANCES RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Aetna Health Inc. **Certificate of Coverage** is hereby amended as follows:

Section P of the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

**P. Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device, including a breast prosthesis, that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is a **Covered Benefit**, when such device is prescribed by a **Participating Provider**, administered through a participating or designated prosthetic **Provider** and pre-authorized by **HMO**. The **Covered Benefit** includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are **Covered Benefits**. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**.

Replacement of the **Member's** prosthetic device, including breast prostheses, that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is a **Covered Benefit**, when such device is prescribed by a **Participating Provider**, administered through a participating or designated prosthetic **Provider** and pre-authorized by **HMO**. The **Covered Benefit** includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are **Covered Benefits**. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**.

The Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

The conversion privilege does not apply to the Prosthetic Appliances Rider.

**AETNA HEALTH INC.  
(TEXAS)**

**COPAYMENT MAXIMUM RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO** Schedule of Benefits is enlarged to include the following:

A **Member's Copayment Maximum** will not apply to prescription drug benefits.

**AETNA HEALTH INC.  
(TEXAS)**

**INPATIENT MENTAL HEALTH RIDER  
(Non-Serious Mental Illness)**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Crisis Stabilization Unit:** A 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions, and which is provided by a facility that is licensed or operated by the appropriate state agency or board to provide such services.
- **Individual Treatment Plan:** A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.
- **Mental Health Treatment Facility:** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medical services that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.
- **Partial Hospitalization:** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Residential Treatment Center:** A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, Healthcare Operations, or the American Association of Psychiatric Services for Children, and which is licensed or operated by the appropriate state agency or board to provide such services.

The Covered Benefits section of this **Certificate** is amended to add the following provisions:

Inpatient benefits are covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital residential facility including a **Mental Health Treatment Facility**, **Crisis Stabilization Unit**, or **Residential Treatment Center** appropriately licensed by the Department of Health or its equivalent. Coverage is subject to the maximum number of days, if any, shown on the below; however, **Coverage** will not be less favorable than for hospital coverage under your particular plan of benefits.

Inpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO**, 1 mental health inpatient day, if any, may be exchanged for up to 2 outpatient or home health visits up to the maximum benefit limitation upon approval by **HMO**.



One (1) inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Requests for exchange must be approved in writing by **HMO** prior to utilization.

Benefits are in conjunction with the **Member's Individual Treatment Plan**.

#### **Copayment**

The **Member** is responsible for a **Copayment** and maximums as follows:

**\$1,500 per admission**

**Maximum of Unlimited days per calendar year**

**AETNA HEALTH INC.  
(TEXAS)**

**COPAYMENT MAXIMUM RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO** Schedule of Benefits is enlarged to include the following:

A **Member's Copayment Maximum** will not apply to **Durable Medical Equipment** benefits.

**AETNA HEALTH INC.  
(TEXAS)**

**CERTIFICATE OF COVERAGE RIDER  
FOR  
SELF-INJECTABLE PRESCRIPTION DRUGS**

**Contract Holder Group Agreement Effective Date: October 1, 2011**

The Definitions section of the **Certificate** is amended to add the following:

- **Self-injectable Drug(s).** Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs** that are not **Covered Benefits** shall be available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com](http://www.aetna.com). The list is subject to change by **HMO** or an affiliate.

The Injectable Medications Benefits in the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- **Injectable Medications Benefits.**

Injectable medications, except **Self-injectable Drugs** eligible for coverage under the Prescription Drug Rider, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one (1) of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one (1) study published in a nationally recognized peer reviewed journal.

**AETNA HEALTH INC.  
(TEXAS)**

**INFUSION THERAPY RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2011

The **HMO Certificate of Coverage** is modified as follows.

The **Home Health Benefits** provision under the Covered Benefits section of the **Certificate** is hereby amended to add the following:

Covered **Home Health** benefits do not include charges for infusion therapy.

The Covered Benefits section is enlarged to include the following:

- **Infusion Therapy**

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are **Medically Necessary** for the **Member's** course of treatment. The following outpatient Infusion Therapy services and supplies are covered for a **Member** when provided by a **Participating Provider**:

- the pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the Infusion Therapy;
- professional services;
- total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis

Refer to the Schedule of Benefits for applicable cost-sharing provisions. Coverage is subject to the maximums, if any, shown on the Schedule of Benefits.

Inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits section of the Covered Benefits section of the **Certificate**.

Coverage for Infusion Therapy benefits is only provided when rendered by **Participating Providers**.

Benefits payable for Infusion Therapy will not count toward any applicable **Home Health Care** maximums.

AETNA HEALTH INC.  
(TEXAS)

**PRESCRIPTION PLAN RIDER**

**Group Agreement** Effective Date: October 1, 2011

**HMO** and **Contract Holder** agree to provide to **Members** the **HMO Prescription Plan Rider**, subject to the following provisions:

**DEFINITIONS**

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Adverse Determination.** A determination upon utilization review that a service or supply is not **Medically Necessary** or appropriate.
- **Brand Name Prescription Drug(s).** Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.
- **Negotiated Charge.** The compensation amount negotiated between **HMO** or an affiliate and a **Participating Retail Pharmacy, Participating Mail Order Pharmacy, or Specialty Pharmacy Network** pharmacy for **Medically Necessary** outpatient prescription drugs and insulin dispensed to a **Member** and covered under the **Member's** benefit plan. This negotiated compensation amount does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drug, including drugs on the **Drug Formulary**.
- **Drug Formulary.** A list of prescription drugs and insulin established by **HMO** or an affiliate, which includes both **Brand Name Prescription Drugs**, and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO** or an affiliate, in accordance with applicable state laws. Notification will be provided as required. **Drug Formulary** changes will be effective upon the renewal date of the **Member's** plan. A copy of the **Drug Formulary** will be available at any time upon request by the **Member** or may be accessed at the pharmacy website, at [www.aetna.com](http://www.aetna.com).
- **Generic Prescription Drug(s).** Prescription drugs and insulin, whether identified by their chemical, proprietary, or non-proprietary name, that are accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate.
- **Maximum Prescription Drug Benefit.** The maximum amount (if any) of prescription drug **Covered Benefits** for any one **Member** in a given calendar year. The maximum does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drugs, including any drugs on the **Drug Formulary**.
- **Maximum Prescription Drug Out-of-Pocket Copayment Limit.** The maximum amount of **Copayments** and the difference in cost between a requested **Brand Name Prescription Drug** and an available **Generic Prescription Drug** equivalent as described in the **Copayments** section of the Prescription Plan Rider that any one **Member** or family must pay during a calendar year. **HMO** will pay 100% of the **Negotiated Charge** for covered outpatient **Brand Name** and **Generic Prescription Drugs** for the remainder of that calendar year.

- **Non-Formulary Prescription Drug(s).** A product or drug not listed on the **Drug Formulary**.
- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.
- **Participating Retail Pharmacy.** A community pharmacy which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs to **Members**.
- **Precertification Program.** For certain outpatient prescription drugs, prescribing **Physicians** must contact **HMO** or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the pharmacy website, at [www.aetna.com](http://www.aetna.com).
  - **Self-injectable Drug(s).** Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered **Self-injectable Drugs**, designated by **HMO** as eligible for coverage under this amendment, shall be available upon request by the **Member** or may be accessed at the **HMO** website, at [www.aetna.com](http://www.aetna.com). The list is subject to change by **HMO** or an affiliate.
- **Specialty Pharmacy Network.** A network of **Participating** pharmacies designated to fill **Self-injectable Drugs** prescriptions.
- **Step Therapy Program.** A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by the **Member**. The list of step therapy drugs is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the pharmacy website, at [www.aetna.com](http://www.aetna.com).

### **COVERED BENEFITS**

The Covered Benefits section of the **Certificate** is amended to add the following provision:

**Members** are required to present their ID card at the time the prescription is filled.

#### **A. Outpatient Prescription Drug Open Formulary Benefit**

**Medically Necessary** outpatient prescription drugs are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, Exclusions and Limitations section described in this rider and the **Certificate**. Coverage is based on **HMO's** or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail or Mail Order Pharmacy**.

**Medically Necessary** diabetic supplies, including insulin, are covered.

**Members** who are receiving coverage for prescription drugs that are removed from the **Drug Formulary** during the **Contract Year** will continue to have those prescription drugs covered at the same benefit level until their plan's renewal date.

- B.** Each prescription is limited to a maximum 30-day supply when filled at a **Participating Retail Pharmacy** or 90-day supply when filled by the **Participating Mail Order Pharmacy** designated by **HMO**. Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail or Mail Order Pharmacy**. Coverage of prescription

drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

- C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer-reviewed journal. Coverage of off label use of these drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations. **Medical Necessity** review will not result in denial of payment if the sole reason for denial is that the prescription drug is being prescribed for off-label usage.

- D. **Emergency Prescriptions** - Emergency prescriptions are covered subject to the following terms:

When a **Member** needs a prescription filled in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside of the **HMO Service Area**, **HMO** will reimburse the **Member** as described below.

When a **Member** obtains an emergency or out-of-area **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, **Member** must directly pay the pharmacy in full for the cost of the prescription. **Member** is responsible for submitting a request for reimbursement in writing to **HMO** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by **HMO** to determine if the event meets **HMO's** requirements. Upon approval of the claim, **HMO** will directly reimburse the **Member** 100% of the cost of the prescription, less the applicable **Copayment** specified below. Coverage for items obtained from a non-**Participating** pharmacy is limited to items obtained in connection with covered emergency and out-of-area **Urgent Care** services. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy**, including an out-of-area **Participating Retail Pharmacy**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s)** as described below. **Members** are required to present their ID card at the time the prescription is filled. **HMO** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** except upon professional review and approval by **HMO** in its sole discretion. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

- E. **Mail Order Prescription Drugs.** Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient prescription drugs are covered when dispensed by the **Participating Mail Order Pharmacy** designated by **HMO** and when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs. **Members** are required to obtain prescriptions greater than a 30-day supply from the designated **Participating Mail Order Pharmacy**. Outpatient prescription drugs will not be covered if dispensed by a **Participating Mail Order Pharmacy** in quantities that are less than a 31-day supply or more than a 90-day supply (if the **Provider** prescribes such amounts).

- F. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Diabetic Supplies.**

Diabetic supplies are covered as a basic plan benefit even though they are obtained from a **Participating Retail** or **Mail Order Pharmacy**.

The following diabetic supplies are covered if **Medically Necessary** upon prescription or upon **Participating Physician's** order only at a **Participating Retail or Mail Order Pharmacy**. The **Member** must pay applicable **Copayments** as described in the Copayments section below for each item.

1. Insulin
2. Diabetic needles/syringes.
3. Test strips for glucose monitoring and/or visual reading.
4. Diabetic test agents.
5. Lancets/lancing devices.
6. Alcohol swabs.
7. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels.
8. Glucagon emergency kits.

- **Contraceptives.**

The following contraceptives and contraceptive devices are covered upon prescription or upon the **Participating Physician's** order only at a **Participating Retail or Mail Order Pharmacy**:

1. Oral Contraceptives.
2. Diaphragms.
3. Injectable contraceptives. The prescription plan **Copayment** applies for each vial.
4. Contraceptive patches.
5. Contraceptive rings.
6. Norplant and IUDs are covered when obtained from a **Participating Physician**. The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any. A **Copayment** for the contraceptive device may also apply.

- **Self-injectable Drugs.**

**Self-injectable Drugs**, eligible for coverage under this amendment, are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The initial prescription must be filled at a **Participating Retail Pharmacy, Participating Mail Order Pharmacy or Specialty Pharmacy Network** pharmacy. Coverage of **Self-injectable Drugs** may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

G. **Copayments.**

**Member** is responsible for the **Copayments** specified in this rider. The **Copayment**, if any, is payable directly to the **Participating Retail or Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/Medicine Quantity	Generic Formulary Prescription Drugs	Brand Name Formulary Prescription Drugs	Non-Formulary Prescription Drugs
Participating Retail Pharmacy Up to a 30-day supply	\$15	\$25	\$40



<b>Participating Mail Order Pharmacy</b> More than a 30-day supply but no more than a 90-day supply	2 times the 30-day supply above	2 times the 30-day supply above	2 times the 30-day supply above
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- H. **Maximum Prescription Drug Benefit** - shall be **unlimited** per **Member** and **unlimited** per family per calendar year.
- I. The family **Maximum Prescription Drug Out-of-Pocket Copayment Limit** is a cumulative **Maximum Prescription Drug Out-of-Pocket Copayment Limit** for all family members.
- J. **Appeals**

**Adverse Determination Appeals.** A **Member** may appeal and seek independent review of an **Adverse Determination** involving a **Prescription Drug** that the **Member's Participating Physician** has prescribed. The processes for appeals and IRO review are described in the **Member's Certificate**.

### **EXCLUSIONS AND LIMITATIONS**

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusions and limitations:

A. **Exclusions:**

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug or for which an equivalent over-the-counter product in strength and dosage form, is available even when a prescription is written), unless otherwise covered by **HMO**.
2. Any drug that, by federal or state law, requires a prescription order and is a pharmaceutical alternative to an over-the-counter drug. This exclusion does not apply to any prescription drug on the **Member's** drug formulary.
3. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
4. Injectable drugs, except for insulin and **Self-Injectable Drugs**.
5. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
6. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps. Coverage for these items is provided in the Covered Benefits section of the **Certificate**.
7. Needles and syringes, except diabetic needles and syringes.
8. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
9. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
10. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
11. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
12. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

13. Drugs prescribed for uses not approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs. This exclusion does not apply to drugs (i) prescribed for uses approved by the FDA, (ii) recognized for off-label indications through one of the standard reference compendia or peer-reviewed medical literature or (iii) otherwise covered under this rider.
14. Medical supplies (except diabetic supplies), devices and equipment and non-medical supplies or substances regardless of their intended use.
15. Test agents and devices, except diabetic test agents.
16. Injectable drugs used for the purpose of treating **Infertility**, except for insulin or unless otherwise covered by **HMO**.
17. Any drug or device that terminates a pregnancy.
18. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
19. Replacement for lost or stolen prescriptions.
20. Performance, athletic performance or lifestyle enhancement drugs and supplies.
21. Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO** or otherwise specifically covered under this rider or the medical plan.
22. Drugs dispensed by other than a **Participating Retail or Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.
23. Medication packaged in unit dose form. (Except those products approved for payment by **HMO**).
24. Prophylactic drugs for travel.
25. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee.
26. Drugs for the convenience of **Members** or for preventive purposes except for the contraceptive coverage specified in this rider, unless covered by **HMO** in its sole discretion.
27. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.
28. Nutritional supplements, except that formulas necessary for the treatment of phenylketonuria, or other heritable diseases are covered under the medical benefits of the **Member's** plan.
29. Smoking cessation aids or drugs.
30. Growth hormones.

**B. Limitations:**

1. A **Member** who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from **HMO**, and **Member** will be responsible for the entire cost of the prescription.
2. A **Participating Retail or Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
3. **HMO** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** or for any drug for which no charge is made to the recipient.
4. Non-emergency and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy** or the **Participating Mail Order Pharmacy**. Refer to the **Certificate** for a description of emergency and **Urgent Care** coverage. **HMO** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy; Participating Mail Order Pharmacy** or a non-**Participating Retail or Mail Order Pharmacy** in non-emergency, non-**Urgent Care** situations. **HMO** retains the right to review all

requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaints and Appeals and Binding Arbitration sections of the **Certificate**.

5. **Member** will be charged the **Non-Formulary Prescription Drug Copayment** for prescription drugs covered on an exception basis.

**AETNA HEALTH INC.  
(TEXAS)**

**AETNA SCHEDULE OF BENEFITS**

**Plan Name: CITIZEN PLAN**  
**Contract Holder Name: City Of Mineral Wells**  
**Contract Holder Group Agreement Effective Date: October 1, 2011**  
**Contract Holder Number: 208434**  
**Contract Holder Locations: 001**  
**Contract Holder Service Areas: TX01**

<b>BENEFITS</b>	
<b><u>Benefit</u></b>	<b><u>Copayment</u></b>
<b>Individual Copayment Maximum: This is the amount of Covered Benefits that are applied to the Member's Copayment Maximum when the Member is enrolled as a single Subscriber.</b>	<b>\$2,000 per Member per calendar year</b>
<b>Family Copayment Maximum: This is the amount of Covered Benefits that are applied to the Member's Copayment Maximum when the Member is enrolled as a family Subscriber.</b>	<b>\$4,000 per family per calendar year</b>
<b>The Family Copayment Maximum is a cumulative maximum for all family members.</b>	
In no instance shall <b>Copayments</b> exceed two hundred percent (200%) of the total annual premium cost which is required to be paid by or on behalf of that <b>Member</b> . The <b>Member</b> must demonstrate that <b>Copayments</b> in excess of such amount have been paid during the year.	
<b>Copayments</b> for certain <b>Covered Benefits</b> specified in the <b>HMO</b> Schedule of Benefits or Riders to the <b>Certificate</b> do not count toward satisfying the <b>Copayment Maximum</b> , and those <b>Covered Benefits</b> are not eligible for 100% reimbursement after the <b>Copayment Maximum</b> is reached. <b>Covered Benefits</b> must be rendered to the <b>Member</b> during that <b>calendar year</b> .	
<b>Maximum Benefit</b>	<b>Unlimited per Member per lifetime</b>

**OUTPATIENT BENEFITS**

<b><u>Benefit</u></b>	<b><u>Copayment</u></b>
<b>Physician Services (Primary Care)</b>	
Adult Physical Examination	
To age 65: 1 visit(s) per 12 months	<b>\$0 per visit</b>
<b>Copayments</b> made by or on behalf of a <b>Member</b> shall not exceed fifty percent (50%) of the total cost of providing any single service to a <b>Member</b> , nor in the aggregate more than twenty percent (20%) of the total cost to the <b>HMO</b> of providing all basic health care services.	

Age 65 or more: 1 visit(s) per 12 months	<b>\$0 per visit</b>
Well Child Physical Examinations, (including Immunizations after the date the child is 6 years of age), as follows:	<b>\$0 per visit</b>
<ul style="list-style-type: none"> <li>• Seven exams in the first 12 months;</li> <li>• Two exams in months 13-24;</li> <li>• One exam every 12 months to age 18</li> </ul>	
Immunizations for children from birth through the date the child is 6 years of age	<b>\$0 copayment</b>
Office Hours Visits	<b>\$40 per visit</b>
After-Office Hours and Home Visits	<b>\$45 per visit</b>
<b>Routine Gynecological Exam(s)</b> 1 visit(s) per 365 consecutive day period	<b>\$0 per visit</b>
<b>Physician Services (Specialty Care)</b>	
Office Visits	<b>\$45 per visit</b>
<b>First Prenatal Visit</b>	<b>\$45</b>
<b>Outpatient Rehabilitation</b>	<b>\$45 per visit</b>
<b>Outpatient Facility Visits</b>	<b>\$45 per visit</b>
<b>Diagnostic X-Ray Testing</b> Performed at a Hospital Outpatient Facility	<b>\$45 per visit</b>
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	<b>\$45 per visit</b>
Performed at a facility other than a Hospital Outpatient Facility	<b>\$45 per visit</b>
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	<b>\$45 per visit</b>
<b>Diagnostic Laboratory Testing</b> Performed at a Hospital Outpatient Facility	<b>\$0 per visit</b>
Performed at a facility other than a Hospital Outpatient Facility	<b>\$0 per visit</b>
<b>Mammography (Diagnostic)</b>	<b>\$45 per visit</b>

**Copayments** made by or on behalf of a **Member** shall not exceed fifty percent (50%) of the total cost of providing any single service to a **Member**, nor in the aggregate more than twenty percent (20%) of the total cost to the **HMO** of providing all basic health care services.

<b>Outpatient Emergency Services</b> Hospital Emergency Room or Outpatient Department	<b>\$150 per visit</b>
<b>Nonhospital Urgent Care Facility</b>	<b>\$75 per visit</b>
<b>Ambulance</b>	<b>\$0 per trip</b>
<b>Outpatient Mental Health Visits</b> Unlimited visits per calendar year	<b>\$45 per visit</b>
<b>Outpatient Serious Mental Illness Visits</b> Unlimited visits per calendar year	<b>\$45 per visit</b>
<b>Outpatient Chemical Dependency Visits</b> Detoxification and Rehabilitation	<b>\$45 per visit/day</b>
Subject to the same Copayment as for physical illness.	
<b>Outpatient Surgery</b> (including colonoscopy) Performed at a Hospital Outpatient Facility	<b>\$500 per visit</b>
Performed at a facility other than a Hospital Outpatient Facility	<b>\$500 per visit</b>
<b>Outpatient Home Health Visits</b>	<b>\$0 per visit</b>
<b>Infusion Therapy</b> Performed during a Physician Office Visit or Home Care Visit	<b>\$45 per visit</b>
Performed at a Hospital Outpatient Department or a facility other than a Hospital Outpatient Facility	<b>\$45 per visit</b>
<b>Maximum Per Visit Limit</b>	<b>Unlimited per visit</b>
<b>Outpatient Hospice Care Visits</b> Unlimited visits per calendar year	<b>\$0 per visit</b>
<b>Maximum Outpatient Hospice Care Benefit</b>	<b>Unlimited per lifetime</b>
<b>Injectable Medications</b>	<b>\$40 per prescription or refill</b>

#### INPATIENT BENEFITS

<u>Benefit</u>	<u>Copayment</u>
<b>Acute Care</b> (Including, but not limited to: inpatient hospital services such as room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services)	<b>\$1,500 per admission</b>

**Copayments** made by or on behalf of a **Member** shall not exceed fifty percent (50%) of the total cost of providing any single service to a **Member**, nor in the aggregate more than twenty percent (20%) of the total cost to the **HMO** of providing all basic health care services.

**Serious Mental Illness**  
**Maximum of Unlimited days per calendar year** **\$1,500 per admission**

**Inpatient Chemical Dependency Visits**  
 Detoxification and Rehabilitation **\$1,500 per admission**

Subject to the same Copayment as for physical illness.

**Maternity** **\$1,500 per admission**

**Skilled Nursing Facility**  
**Maximum of Unlimited days per calendar year** **\$1,500 per admission**

**Hospice Care**  
 Maximum of Unlimited days per calendar year **\$1,500 per admission**

### **Transplants**

**Transplant Facility Expense Services**

**When provided at an Institute of Excellence™ (IOE) Facility** **\$1,500 per admission**

**Transplant Benefits Maximum:**

**Lifetime Benefit Maximum for all Transplant Benefits incurred while covered under any Aetna or Aetna-affiliated plan. Unlimited**

**Subscriber Eligibility:** All eligible, active full-time employees of the **Contract Holder** who regularly work at least the minimum number of hours per week as defined by the **Contract Holder** and agreed to by **HMO**.

Eligible for benefits on the first of the month following 30 days from the date of hire.

**Dependent Eligibility:** A dependent unmarried child as described in the Eligibility and Enrollment section of the **Certificate** who is:

- i. under 26 years of age; or
- ii. medically certified as disabled, chiefly dependent upon the **Subscriber** for support and maintenance and has reached the age specified in Paragraph “i” above; or
- iii. more than 25 years of age and enrolled as a full-time student at the start of an academic term. Coverage shall terminate on the 11th day of instruction of the subsequent academic term in the event full-time student status ends prior to the end of the previous academic term and the dependent has not returned to full-time student status before that day.

**Copayments** made by or on behalf of a **Member** shall not exceed fifty percent (50%) of the total cost of providing any single service to a **Member**, nor in the aggregate more than twenty percent (20%) of the total cost to the **HMO** of providing all basic health care services.

## **IMPORTANT HEALTH CARE REFORM NOTICES**

### **CHOICE OF PROVIDER**

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.